Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17001

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joseph L. Miller
2. Date of Death: Month JUNE Day 5, Year 1997
3. Time of Death: 9:00 am
4a. Facility Name (If not institution, give street and number): GREATER BALTIMORE MEDICAL CENTER
4b. City, Town, or Location of Death: TOWSON
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 216 12 0380
6. Sex: 1☑ M 2☐ F
7. Age (In yrs. last birthday): 74 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): August 15 1922
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Timonium
10d. Inside City Limits: 1☐ Yes 2☑ No
10e. Street and Number: 128 Green Meadow Drive
10f. Zip Code: 21093
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☑ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☑ Yes 2☐ No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Supervisor
16b. Kind of Business/Industry: AT & T

17. Father's Name (First, Middle, Last): Joseph L. Miller
18. Mother's Name (First, Middle, Maiden Surname): Catherine Devine

19a. Informant's Name/Relationship (Type, Print): Mary Jane Miller Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 128 Green Meadow Dr. Timonium, Maryland 21093

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): Dulaney Valley Memorial Gardens
Date: June 9 1997
20c. Location - City or Town, State: Timonium, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Evans Chapel of Chimes 2325 York Rd. Timonium Md. 21093

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. PULMONARY FIBROSIS
Due to (or as a consequence of):
b. RESPIRATORY FAILURE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: D0051252
29d. Date signed (Month, Day, Year): June 5, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID GOODFRIEND - GBMC 6701 N. CHARLES ST. BALTIMORE 21204

State Registrar

31. Date filed (Month, Day, Year): JUN 06 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Joseph Leo Miller
Baltimore, Maryland 21215-0820

permit. Pages 1 and 2 should be filed within 24 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural' or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17002

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ESTELLE MARIE MONKS
2. Date of Death Month/Day/Year: JUNE 02, 1997
3. Time of Death: 8:45 PM
4a. Facility Name *(If not institution, give street and number)*: Saint Joseph Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 214-12-0284
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Dec. 24 1911
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Timonium
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 800 W. Padonia Rd.
10f. Zip Code: 21030
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 3 | College (1-4or 5+): n/a
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: George Bernard Topper
18. Mother's Name *(First, Middle, Maiden Surname)*: Margaret Elizabeth Tabling

19a. Informant's Name/Relationship *(Type, Print)*: Shirley E. Nash/Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 101 Oakway Rd., Timonium, MD 21093

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Carroll Cremation Service | Date: 6/3/97
20c. Location - City or Town, State: Hampstead, MD

21. Signature of Funeral Service Licensee: Victor Lengrand Jr. Victor Lengrand, Jr.
22. Name and Address of Facility: Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. ASPIRATION PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CONGESTIVE HEART FAILURE

TYPE II DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D37254
29d. Date signed *(Month, Day, Year)*: 6-3-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BOON P. LIM, M.D. , 7620 YORK ROAD TOWSON, MARYLAND 21204

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed *(Month, Day, Year)*: JUN 06 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17003

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JUDITH H. MOFFSON

2. Date of Death: Month June, Day 2, Year 1997

3. Time of Death: 1:00 A. M.

4a. Facility Name (If not institution, give street and number): Hebrew Home of Greater Washington

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 202-22-4949

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): June 14, 1917

9. Birthplace (State or Foraign Country): New York

Usual Residenca of Decedant

10e. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 6121 Montrose Road

10f. Zip Code: 20852

10g. Citizen of Whet Country?: U. S. A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorcad

12. Was Decadent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No. If Yes, Giva Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No. Specify:

14. Race - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elemantary/Secondary (0-12): 12 Years; Collaga (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT use retired): Retail Sales

16b. Kind of Business/Industry: Clothing

17. Father's Name (First, Middle, Last): Harry Schoenbrun

18. Mother's Name (First, Middle, Maiden Surname): Gizella

19a. Informant's Name/Relationship (Type, Print): Stanley Moffson

19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13755 Lakeside Drive, Clarksville, Maryland 21029

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Placa of Disposition (Name of cametery, crematory or other place): King David Memorial Park

Date: 6/3/1997

20c. Location - City or Town, State: Bensalem, Pennsylvania

21. Signature of Funaral Servica Licensee: ▶ Donald S. Stottlemyer

22. Name and Address of Facility: STEIN HEBREW MEMORIAL FUNERAL HOME, INC. 232 CARROLL STREET, N.W., WASHINGTON, D.C. 20012

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Intervel Batween Onset and Death

Immediate Ceuse (Finai disease or condition resulting in death)
a. ASPIRATON PNEUMONIA, LOWER LOBES — 10 DAYS

Due to (or es e consequenca of):
b. DEMENTIA OF ALZHEIMER'S TYPE

Sequantially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in daath) Lest

Due to (or as a consequenca of):
c.

Due to (or as a consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Wara autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA; Othar: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Panding Investigation 6☐ Could not be detarmined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Placa of Injury - At home, farm, streat, factory, offica building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, end due to the causa(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurred at tha tima, data end placa, end due to the cause(s) end manner stated.

29b. Signature and title of certifier: ▶ Attending Physician

29c. License number: D18084

29d. Date signed (Month, Day, Year): JUNE 02, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): D. J. PATEL, M.D. 6121 MONTROSE RD, ROCKVILLE MD 20852

State Registrar

31. Date filed (Month, Day, Year): JUN 06 1997

32. Registrar's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Item26 6-6-97 FilmG748 W.H.Per Doctor

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17004

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Sonia, McPhail

2. Data of Death: Month May Day 19 Year 1997

3. Time of Death: 05:00

4a. Facility Name (If not institution, give street and number): 4607 Old Frederick Road #C

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-38-7275

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 55 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Dey, Yaer): July 08, 1941

9. Birthplaca (State or Foraign Country): Maryland

Usual Raidance of Decedent

10a. Stata: Md.

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yas 2☐ No

10e. Street and Number: 4607 Old Frederick Road #C

10f. Zip Coda: 21229

10g. Citizan of What Country?: USA

11. Marital Status: ☒ Navar Married 2☐ Marriad 3☐ Widowad 4☐ Divorced

12. Was Decedant Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:

14. Race - Amarican Indian, Black, White, atc. Specify: Black

15. Decedant's Educetion (Specify only highast grada complatad): Elamentary/Secondary (0-12): 10th grade | Collega (1-4or 5+):

16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratirad): Domestic

16b. Kind of Businass/Industry: Own home

17. Fathar's Nama (First, Middla, Last): John McPhail

18. Mothar's Nama (First, Middla, Maiden Surnama): Nellie Lee Underwood

19a. Informant's Name/Ralationship (Type, Print): Nellie McPhail (mother)

19b. Mailing Address (Straet and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 4607 Old Frederick Road, Baltimore, Maryland 21229

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)

20b. Placa of Disposition (Nama of camatary, cremetory or othar placa): Western Star Cemetery | Data: 5-23-97

20c. Location - City or Town, Stata: Catonsville, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Nama and Address of Facility: Joseph H. Brown Jr. Funeral Homes, P.A. 2140 N. Fulton Avenue, Baltimore, Maryland 21217

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only ona causa on aach line.

Approximata Interval Batwaan Onsat and Daath

Immediate Causa (Finat disaasa or condition rasulting in death):
a. Mycobacterium Avium Complex — 2 Yrs.
Due to (or as a consequence of):
H I V — 7 Yrs.

Saquantially list conditions, if any, laading to immadiata ceusa. Enter Undarlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last:
b. Dua to (or as a consequance of):
c. Dua to (or as a consequance of):
d.

Part II. **Othar significant conditions** contributing to death but not rasulting in tha undarlying ceusa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to completion of ceuse of death? 1☐ Yas 2☒ No

25. Was cesa rafarrad to medical examinar? 1☐ Yas 2☒ No

26. Placa of Daath (Chack only one): Hospital: 1☐ Inpatiant 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Homa 5☒ Rasidance 6☐ Othar (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding Investigation 6☐ Could not be datarminad

28a. Data of Injury (Month, Dey Yaar)

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28e. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28f. Location (Straet and Numbar or Rural Routa Number, City or Town, Stata)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at tha time, date and place, end due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, end dua to tha ceusa(s) and mannar stated.

29b. Signature and title of certifiar: [signature], MD — Medical Resident, St. Agnes Hospital

29c. Licensa number: 80938

29d. Data signed (Month, Day, Year): May 21, 1997

30. Name end addrass of person who completed cause of death (Item 23a) (Type, Print): M Shannon Peattie, M.D. — 900 Caton Ave. Baltimore, Md - 21229

State Registrar

31. Data filed (Month, Day, Yaar): JUN 06 1997

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17005

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Albert Maivelett Sr.

2. Dete of Deeth — Month: 6 Dey: 3 Yeer: 97

3. Time of Deeth: 930 Am

4e. Fecility Neme *(If not institution, give street end number)*: Johns Hopkins Bayview Hosp.

4b. City, Town, or Location of Deeth: Baltimore

4c. County of Deeth:

Funeral Director

5. Social Security Number: 218-09-3840

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 76 Yrs.

If Under 1 Yeer: Months: Days: If Under 24 Hrs.: Hours: Min.:

8. Dete of Birth *(Month, Dey, Yeer)*: Nov. 17, 1920

9. Birthpiece *(State or Foreign Country)*: Maryland

Usuel Residence of Decedent

10e. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street end Number: 4725 Shamrock Ave.

10f. Zip Code: 21206

10g. Citizen of Whet Country?: USA

11. Marital Status: 1 ☐ Never Merried 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 6th; College (1-4or 5+):

16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Steel Mill

16b. Kind of Business/Industry: Beth Steel

17. Fether's Name *(First, Middle, Last)*: Louis Maivelett

18. Mother's Name *(First, Middle, Maiden Surneme)*: Antoinette Izzo

19e. Informent's Name/Reletionship *(Type, Print)*: Elsie V. Maivelett/wife

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 4725 Shamrock Ave. Baltimore Md. 21206

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other *(Specify)*

20b. Plece of Disposition *(Name of cemetery, cremetory or other piece)*: DulaneyValleyCemetery

Date: 6/7/97

20c. Location - City or Town, State: Baltimore Md.

21. Signeture of Funerel Servica Licensee: R. Terry Connelly

22. Neme and Address of Fecility: Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immediete Ceuse (Finel diseese or condition resulting in death)

e. end stage congestive heart failure — months

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in death) Lest

b. severe coronary artery dz. — months

Due to (or es e consequence of):

c. peripheral vascular dz. — years

Due to (or es e consequence of):

d.

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cauee of death? 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24e. Wes en eutopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical exeminer? 1 ☐ Yes 2 ☒ No

26. Plece of Deeth *(Check only one)*: Hospital: 1 ☒ Unpetient 2 ☐ ER/Outpetient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Netural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28e. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physicien:** To the best of my knowledge, deeth occurred et the time, dete and plece, end due to the ceuse(s) end menner es steted. 2 ☐ **Medical Examiner:** On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete and piaca, end due to the cause(s) and manner steted.

29b. Signeture end title of certifier: Hyon Seo

29c. License number: 96712

29d. Date signed *(Month, Dey, Yeer)*: 6/3/97

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Hyon Seo Johns Hopkins Bayview Hosp.

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: JUN 06 1997

32. Registrar's Signature: Judy Davidson-Randall

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "Natural", or if item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17006

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Margaret O'Brien
2. Date of Death Month Day Year: June 4, 1997
3. Time of Death: 0340
4a. Facility Name *(If not institution, give street and number)*: Anne Arundel Medical Center
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 030-24-9483
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 64 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sept. 26, 1932
9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Annapolis
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 941 Tidewater Grove Court
10f. Zip Code: 21401
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Librarian/Researcher
16b. Kind of Business/Industry: Newspaper

17. Father's Name *(First, Middle, Last)*: Edwin Coulson
18. Mother's Name *(First, Middle, Maiden Surname)*: Geneva Jensen

19a. Informant's Name/Relationship *(Type, Print)*: Joseph A. O'Brien/Spouse
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 941 Tidewater Grove Ct. Annapolis, Md. 21401

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory
Date: 6-6-97
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Hardesty Funeral Home P.A. 12 Ridgely Avenue Annapolis, Md. 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Enter only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Pneumonia	
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Left hemispheric stroke	
Due to (or as a consequence of):		
	c. Metastatic lung cancer	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D.
29c. License number: D44465
29d. Date signed *(Month, Day, Year)*: 06/04/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ann C. Mezey, M.D., 900 Bestgate Road, Annapolis, MD 21401

State Registrar

31. Date filed *(Month, Day, Year)*: JUN 06 1997
32. Registrar's Signature: [signature]

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the local registrar after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

20

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item8 6-9-97 FilmG748 W.H.Per F/H

Certificate of Death

Reg. No. 97 17007

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): VIRGIL J. PRATER
2. Date of Death: Month MAY Day 28 Year 1997
3. Time of Death: 05:13 AM
4a. Facility Name (If not institution, give street and number): NORTH ARUNDEL HOSPITAL
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 412-56-6708
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 58 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): August 15, 1938
9. Birthplace (State or Foreign Country): TENN.

Usual Residence of Decedent

10a. State: M.D.
10b. County: A.A.Co
10c. City, Town or Location: Glen Burnie
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 127 Linwood Ave.
10f. Zip Code: 21061
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Nevar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorcad
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | Collega (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Self Employed
16b. Kind of Business/Industry: Flooring Contr.

17. Father's Name (First, Middle, Last): Samuel Prater
18. Mother's Name (First, Middle, Meiden Surname): Mary Paul

19a. Informent's Name/Relationship (Type, Print): Mary K. Prater (wife)
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 127 Linwood Ave. Glen Burnie MD. 21061

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other pleca): Cedar Hill cemetery
Date: May 31, 1997
20c. Location - City or Town, State: Brooklyn. Md

21. Signature of Funeral Service Licensee: Thomas J. Rhoda Jr
22. Name and Address of Facility: The Raymond C. Fink Funeral Home 426 Crain Hwy. Glen Burnie MD. 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Acute Myocardial Infarction — 1 day.

Due to (or as a consequance of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequance of):
c.
Due to (or as a consequanca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

End Stage renal disease on hemodialysis, Diabetes, Ischemic Cardiomyopathy.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Panding Investigation 6 [ ] Could not be datarmined

28a. Data of Injury (Month, Day Yeer)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: T-A. Zayden MD
29c. License number: D 51010
29d. Date signed (Month, Day, Year): May, 28, 1997

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): Muhammad Zayedan, MD. North Arundel Hospital.

State Registrar

31. Date filed (Month, Day, Year): JUN 06 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

2

3

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17008

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jerome F. Pivec Sr.

2. Date of Death Month Dey Yeer: June 4 1997

3. Time of Death: 4:20 pm

4e. Facility Name (If not institution, give street and number): Stella Maris Hospice

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-10-4231

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthdey): 85 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Yeer): Jan. 8, 1912

9. Birthplace (State or Foreign Country): Maryland

Usuel Residence of Decedent

10e. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimroe

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2607 Pearwood Road

10f. Zip Code: 21234

10g. Citizen of What Country?: U. S. A.

11. Maritel Stetus: 1☐ Never Married 2☐ Merried 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondery (0-12): 12th Grade

College (1-4or 5+):

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Plumber

16b. Kind of Business/Industry: Self-Employed Plumbing Company

17. Father's Neme (First, Middle, Last): Frank Pivec

18. Mother's Name (First, Middle, Meiden Surneme): Antionette Vacek

19e. Informant's Neme/Reletionship (Type, Print): Nancy Pool (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 2208 Greenhaven Way, Hampstead, Md. 21074

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other plece): Gardens of Faith

Dete: 6/7/97

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee:

22. Neme end Address of Feclility: Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Maryland 21213

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert failure. List only one ceuse on eech line.

Approximete Interval Between Onset end Death

Immediete Cause (Finel diseese or condition resulting in death)

a. Coronary Artery Disease

Due to (or as a consequence of):

b. Cerebrovascular Accident

Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest

Due to (or as a consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobecco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one)

Hospital: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA

Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer):

28b. Time of Injury M:

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete and plece, and due to the cause(s) and menner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred at the time, dete end plece, and due to the cause(s) and menner steted.

29b. Signature and title of certifier:

29c. License number: D 15504

29d. Date signed (Month, Dey, Yeer): 6-5-97

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print): Eddie Nakhuda, M.D. 2300 Dulaney Valley Rd., Timonium, Md. 21093

State Registrar

31. Dete filed (Month, Dey, Yeer): JUN 06 1997

32. Registrar's Signeture:

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "Natural" or Items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Item1 6-9-97 FilmG748 W.H.Per Doctor
Item1 6-6-97 FilmG748 W.H.Per Doctor

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17009

Physician /Medical Examiner

1. Decadant's Nama (First, Middla, Last): PIPKIN, RETHA Retha ~~Reatha~~ Pipkin
2. Data of Daath — Month: JUNE Day: 3, Yaar: 1997
3. Tima of Death: 7'9 AM
4a. Facility Nama (If not institution, giva street and number): OLD COURT NURSING CENTER
4b. City, Town, or Location of Deth: RANDHISTOWN
4c. County of Deeth: BALTIMORE

Funeral Director

5. Social Sacurity Number: 218.18.6775
6. Sex: 1☐ M 2☑ F
7. Aga (In yrs. last birthday): 84 Yrs.
If Undar 1 Yaar — Months: ; Days:
If Undar 24 Hrs. — Hours: ; Min.:
8. Date of Birth (Month, Day, Yaer): May 17, 1913
9. Birthplaca (Stata or Foreign Country): N.C.

Usual Rasidanca of Decadant

10a. Stata: MD
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yas 2☑ No
10e. Straat and Numbar: 5412 old Court Road
10f. Zip Coda:
10g. Citizan of Whet Country?: USA

11. Marital Status: 1☐ Navar Married 2☐ Marriad 3☐ Widowad 4☑ Divorced
12. Was Dacadant Evar in U.S. Armed Forcas? 1☐ Yas 2☑ No — If Yas, Giva Yaar or Dates:
13. Was Dacedent of Hispanic Origin? (Spacify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.): 1☐ Yas 2☑ No — Specify:
14. Raca - Amarican Indian, Black, Whita, etc. — Spacify: Black

15. Dacadant's Education (Spacity only highast grada compliated) — Elamentary/Sacondary (0-12): 12th — Collaga (1-4or 5+): NA
16a. Decadant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired): CAFETERIA WORKER
16b. Kind of Businass/Industry: Stewart & Company

17. Fathar's Nama (First, Middla, Last): Gaston McCallum
18. Mothar's Name (First, Middle, Maiden Sumame): MARY CADE

19a. Informant's Name/Raletionship (Type, Print): Sylvia Joyner - Daughter
19b. Mailing Address (Streat and Number or Rural Route Number, City or Town, Stata, Zip Code): 4820 Norwood Ave Balto. md 21207

20a. Mathod of Disposition: 1☑ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donetion 5☐ Othar (Specify)
20b. Place of Disposition (Name of camatary, cramatory or othar placa): King Memorial Park
Date: 6/2/97
20c. Locatlon - City or Town, Steta: Randallstown, Md

21. Signature of Funaral Sarvice Licensee: Glynis B. Harris
22. Nama and Address of Facility: March Funeral Home-West 4300 Wabash Ave. Balto. md 21215

Physician /Medical Examiner

23e. Part I. Enter tha disease, or complications that ceusad tha daath. Do not anter the moda of dying, such es cerdiac or raspiratory arrast, shock, or haart failure. List only ona cause on aach lina.

Approximata Interval Batwaan Onset end Death

Immadiete Causa (Final disaasa or condition resulting in daath)
a. Cerebrovascular accidents
Dua to (or es e consequance of):
Sequantially list conditions, if any, leading to immedieta ceuse. Entar Undarlying Causa (Disease or injury that initiated avants resulting in daath) Last
b.
Dua to (or as a consequenca of):
c.
Due to (or as e consequance of):
d.

Part II. **Other significant conditions** contributing to daath but not resulting in tha undarlying ceusa given in Part I.
Seizures 2° to cerebrovascular accident
Pneumonia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☑ No
24b. Wara autopsy findings available prior to compilation of cause of daath? 1☐ Yas 2☐ No

25. Was case refarred to medical axaminar? 1☐ Yas 2☑ No
26. Placa of Death (Check only ona) — Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA — Other: 4☑ Nursing Home 5☐ Rasidance 6☐ Othar (Specify)
27. Mannar of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Panding Invastigation 6☐ Could not be datarmined
28a. Data of Injury (Month, Day Yaar)
28b. Tima of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Dascribe how injury occurred
28e. Piece of Injury - At homa, farm, streat, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Cartifiar (Check only one): 1☑ **Certifying Physician:** To the best of my knowledga, daath occurred at tha time, dete and place, and due to the causa(s) and manner es stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar statad.
29b. Signature and title of certifier: Jerome H. Ginsberg MD
29c. Licansa number: D20964
29d. Data signed (Month, Day, Year): June 3, 1997
30. Nama and address of person who completed ceusa of deeth (Item 23a) (Type, Print): Jerome H. Ginsberg, M.D. 8630 Liberty Plaza Mall Randallstown, MD 21133

State Registrar

31. Data filed (Month, Day, Year): JUN 06 1997
32. Registrar's Signature: Jackie Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or if there is a history of any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 17010

Certificate of Death Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Michael Penyak
2. Date of Death Month: June Day: 4 Year: 1997
3. Time of Death: 11:45
4a. Facility Name *(If not institution, give street and number)*: St. Agnes Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 169-18-8380
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 09/26/1920
9. Birthplace *(State or Foreign Country)*: Old Forge, PA

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Arbutus
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1014 Elm Road
10f. Zip Code: 21227
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1942-46
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Manager
16b. Kind of Business/Industry: Telephone

17. Father's Name *(First, Middle, Last)*: Charles Penyak
18. Mother's Name *(First, Middle, Maiden Surname)*: Anna Palesczak

19a. Informant's Name/Relationship *(Type, Print)*: Margaret J. Penyak
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1014 Elm Road Arbutus MD 21227

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Loudon Park Cemetery | Date: 6-7-1997
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee
22. Name and Address of Facility: Ambrose Funeral Home, Inc. 1328 Sulphur Spring Road Arbutus MD 21227

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia — 5 Days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as e consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Prostate carcinoma, Bladder carcinoma
Spinal cord compression

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD — Internal Medicine Resident
29c. License number: P11040
29d. Date signed *(Month, Day, Year)*: JUN 04, 1997
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): M. Shannon Peuffic, MD 900 Caton Ave Baltimore, MD 21229 St. Agnes Hospital

State Registrar

31. Date filed *(Month, Day, Year)*: JUN 06 1997
32. Registrar's Signature: [signature] Davidson-Randall

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

15

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17011

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elizabeth M. Petz

2. Date of Death: Month June Day 4th Year 1997

3. Time of Death: 4:15 AM

4a. Facility Name (If not institution, give street and number): Howard county general hospital

4b. City, Town, or Location of Death: Columbia

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 215-01-5128

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 16, 1912

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: CATONSVILLE

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 208 WESTSHIRE DRIVE

10f. Zip Code: 21228

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10TH GRADE; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER

16b. Kind of Business/Industry: HOMEMAKING

17. Father's Name (First, Middle, Last): ARTHUR MERCER

18. Mother's Name (First, Middle, Maiden Surname): NETTIE McCABE

19a. Informant's Name/Relationship (Type, Print): H. ALBERT PETZ, JR (NEPHEW)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1403 PURDUE COURT - BELAIR, MARYLAND 21014

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): LOUDON PARK CEMETERY Date: 6/6/97

20c. Location - City or Town, State: BALTIMORE

21. Signature of Funeral Service Licensee: Teresa L Klug

22. Name and Address of Facility: HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Cardio-respiratory failure	6 days
Due to (or as a consequence of): b.	Pneumonia	6 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last. Due to (or as a consequence of): c.	acute urinary tract infection	6 days
Due to (or as a consequence of): d.	Mitral valve prolapse	several yrs

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: C Mehta MD

29c. License number: D34974

29d. Date signed (Month, Day, Year): June 4th 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHARU MEHTA, 5865 Robert Oliver pl, #121, Columbia, MD 21045

State Registrar

31. Date filed (Month, Day, Year): JUN 06 1997

32. Registrar's Signature: Julie Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the Father death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

17

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 17012

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary R. Romeo

2. Date of Death — Month: June Day: 6, Year: 1997

3. Time of Death: 4:10 A.M.

4a. Facility Name (If not institution, give street and number): Ivy Hall Geriatric & Rehabilitation Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-05-7022

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 93 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 9, 1904

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Joppa

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 642 C. Harborside Drive

10f. Zip Code: 21085

10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): N/A — College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Operator Men's Clothing

16b. Kind of Business/Industry: Clothing Company

17. Father's Name (First, Middle, Last): Vincent Romeo

18. Mother's Name (First, Middle, Maiden Surname): Madeline Ferraro

19a. Informant's Name/Relationship (Type, Print): Michael D. Ferracci (Nephew)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 802 Chaatfield Road, Joppa, Maryland 21085

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Parkwood Cemetery — Date: 6/ 10/97

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Maryland 21213

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or if item 28a or 28c is "Yes", show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Metastatic Colon Cancer — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Basha Karakash, M.D.

29c. License number: D 47813

29d. Date signed (Month, Day, Year): June 6 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BASHAR KARAKASH 3007 E. Northern Parkway Baltimore MD 21214

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): JUN 06 1997

32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item26 6-6-97 FilmG748 W.H.Per Doctor

Certificate of Death

Reg. No. 97 17013

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: William John Rupp
2. Date of Death Month Day Year: May 24, 1997
3. Time of Death: 8:40 PM
4a. Facility Name *(If not institution, give street and number)*: 762 Fulbrook Road
4b. City, Town, or Location of Death: Dundalk
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-20-5029
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Oct. 13, 1926
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residance of Decedant

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 762 Fulbrook Road
10f. Zip Code: 21222
10g. Citizen of What Country?: United States
11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Years | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Welder
16b. Kind of Business/Industry: Environmental Elements
17. Father's Name *(First, Middle, Last)*: John Rupp
18. Mother's Name *(First, Middle, Maiden Surname)*: Catherine Winkler
19a. Informant's Name/Relationship *(Type, Print)*: Bernadette D. Rupp/Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 762 Fulbrook Road Dundalk, Maryland 21222
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Sacred Ht. of Jesus Cem. Date: 5/29/97
20c. Location - City or Town, State: Dundalk, Maryland
21. Signature of Funeral Service Licensee: Gregory E. Ruck
22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Carcinomatosis — Approx. mos.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residance 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Richard Magno, Co
29c. License number: D09350
29d. Date signed *(Month, Day, Year)*: 5/28/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): R. S. MAGNO M.D. 7811 Wise Ave Balto. MD 21222

State Registrar

31. Date filed *(Month, Day, Year)*: JUN 06 1997
32. Registrar's Signature: Lydia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17014

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JOSEPH KENNARD ROGERS JR.

2. Date of Death Month / Day / Year: JUNE 4, 1997

3. Time of Death: 10:22 a.m.

4a. Facility Name *(If not institution, give street and number)*: Stella Maris

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-18-5709

6. Sex: [X] 1 M [ ] 2 F

7. Age *(In yrs. last birthday)*: 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 18, 1921

9. Birthplace *(State or Foreign Country)*: MAryland

Usual Residence of Decedent

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Essex

10d. Inside City Limits: [ ] 1 Yes [X] 2 No

10e. Street and Number: 822 Middlesex Road

10f. Zip Code: 21221

10g. Citizen of What Country?: USA

11. Marital Status: [ ] 1 Never Married [X] 2 Married [ ] 3 Widowed [ ] 4 Divorced

12. Was Decedent Evar in U.S. Armed Forcas? [X] 1 Yes [ ] 2 No If Yes, Give Yaar or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- if Yes, specify Cuban, Maxican, Puarto Rican, etc.) [ ] 1 Yea [X] 2 No *Specify:*

14. Race - Amaricen Indlan, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grada completed)*: Elementary/Secondary (0-12): 8th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work dona during most of working life. DO NOT use retired)*: Steel Worker

16b. Kind of Business/Industry: Beth Steel

17. Father's Name *(First, Middle, Last)*: Joseph K. Rodgers Sr.

18. Mother's Nama *(First, Middle, Maiden Surname)*: Violet May Hampton

19a. Informant's Name/Relationship *(Type, Print)*: H.Virginia Rogers/wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 822 Middlesex Road Baltimore Md. 21221

20a. Method of Disposition: [X] 1 Burial [ ] 2 Cremation [ ] 3 Removal from State [ ] 4 Donation [ ] 5 Other *(Specify)*

20b. Placa of Disposition *(Name of cemetery, crematory or other place)*: Gardens of Faith

Data: 6/7/97

20c. Location - City or Town, State: Rossville Md.

21. Signature of Funeral Sarvica Licensee: R. Terry Connelly

22. Name and Address of Facility: Connelly Funeral Home of Essex, 300 Mace Ave. Baltimore Md. 21221

To Be Completed by Funeral Director

Baltimore, Maryland 21215 6/6/97

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that ceusad tha death. Do not enter the moda of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one cause on each line.

Approximate Interval Between Onsat and Death

Immediate Cause (Final diseasa or condition resulting in death): a. COLON CA LIVER METS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? [ ] 1 Yes [X] 2 No [ ] 3 Probably [ ] 4 Unknown

24a. Was an autopsy performed? [ ] 1 Yes [X] 2 No

24b. Were autopsy findings available prior to completion of cause of death? [ ] 1 Yes [ ] 2 No

25. Was case referred to medical examiner? [ ] 1 Yes [X] 2 No

26. Place of Death *(Check only one)*: Hospital: [ ] 1 Inpatient [ ] 2 ER/Outpatient [ ] 3 DOA; Other: [ ] 4 Nursing Homa [ ] 5 Rasidence [X] 8 Other *(Specify)* HOSPICE

27. Manner of Death: [X] 1 Natural [ ] 2 Accident [ ] 3 Suicide [ ] 4 Homicide [ ] 5 Pending Investigation [ ] 6 Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? [ ] 1 Yes [ ] 2 No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: [X] 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. [ ] 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D33-215

29d. Date signed *(Month, Day, Year)*: 06/04/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. SHIRLEY THOMPSON-RICHARDS 2300 DULANEY VALLEY TIMONIUM, MD 21093

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

12

State Registrar

31. Date filed *(Month, Day, Year)*: JUN 06 1997

32. Registrar's Signature: Jackie Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17015

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Lest): Russell E. Schreiber
2. Dete of Death — Month: June; Dey: 3; Yeer: 1997
3. Time of Deeth: 7:33 pm
4e. Feciity Name (If not institution, give street end number): Genesis Eldercare / Perring Parkway Center
4b. City, Town, or Location ot Death: Parkville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 705 03 1194
6. Sex: 1☑ M 2☐ F
7. Age (In yrs. last birthday): 86 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Yeer): December 24 1910
9. Birthpiece (Stete or Foreign Country): Maryland

Usuel Residence of Decedent

10e. Stete: Maryland
10b. County: Baltimore
10c. City, Town or Location: Parkville
10d. Inside City Limits: 1☐ Yes 2☑ No
10e. Street end Number: 2610 Wentworth Rd.
10f. Zip Code: 21234
10g. Citizen of Whet Country?: USA
11. Maritel Stetus: 1☐ Never Married 2☑ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- It Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 1☐ Yes 2☑ No Specify:
14. Race - Americen Indien, Bleck, White, etc. Specify: White
15. Decedent's Education (Specify only highest grede completed): Elementery/Secondary (0-12): 12; College (1-4or 5+): 2
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Assistant to Treasurer
16b. Kind ot Business/Industry: B & O Railroad
17. Father's Name (First, Middle, Last): William Schreiber
18. Mother's Neme (First, Middle, Melden Surneme): Margaret Wendler
19e. Intorment's Name/Reletionship (Type, Print): Wayne Schreiber Son
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 2209 Aquilas Delight Fallston, Maryland 21047
20e. Method of Disposition: 1☑ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): Dulaney Valley Memorial Gardens
Dete: June 6 1997
20c. Location - City or Town, Stete: Timonium, Maryland
21. Signeture of Funerel Service Licensee: [signature]
22. Neme end Address of Feciity: Evans Chapel of Memories 8800 Harford Rd. Baltimore, Md. 21234

Physician /Medical Examiner

23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert teilure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immediate Ceuse (Finel diseese or condition resulting in deeth)
e. Pneumonia — 1 Day
Due to (or es e consequence ot): Severe Chronic Obstruction
Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest
b. Due to (or es e consequence of): Guy Rises — 4 yeas
c. Due to (or es e consequence of):
d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.: Major Depression

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings evelleble prior to completion ot ceuse ot deeth? 1☐ Yes 2☐ No

25. Wes cese referred to medical exeminer? 1☐ Yes 2☑ No

26. Piece ot Deeth (Check only one) — Hospital: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner ot Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer)
28b. Time ot Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place ot Injury - At home, tarm, street, fectory, office building, etc. (Specify)
28t. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best ot my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis ot exeminetion end/or investigetion, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) and menner stated.

29b. Signeture end title of certifier: [signature]
29c. License number: D08355
29d. Dete signed (Month, Dey, Yeer): JUNE 4 1997

30. Neme and eddress of person who completed cause ot deeth (Item 23e) (Type, Print): Gracito Patricio M.D. 8903 Harford Rd. Baltimore, Maryland 21234

State Registrar

31. Dete filed (Month, Day, Yeer): JUN 06 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

16

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17016

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Sally L Schmitt

2. Date of Death Month Jun Day 04 Year 1997

3. Time of Death 9 07AM

4a. Facility Name *(If not institution, give street end number)*: Howard County General Hospital

4b. City, Town, or Location of Death: Columbia

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 211 07 7068

6. Sex: 1☐ M 2☒ F

7. Age *(in yrs. last birthday)*: 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Aug 7, 1915

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: PA

10b. County: Westmoreland

10c. City, Town or Location: New Kensington

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 1015 Edgewood Rd.

10f. Zip Code: 15068

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):

18a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Broker

16b. Kind of Business/Industry: Real Estate

17. Father's Name *(First, Middle, Last)*: David Calvin Byers

18. Mother's Name *(First, Middle, Maiden Surname)*: Laura Miller

19a. Informant's Name/Relationship *(Type, Print)*: Susan J. Gombos daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9508 Nightsong Lane, Columbia, Md. 21046

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Greenwood Memorial Park

Date: 6/07/97

20c. Location - City or Town, State: Lower Burrell, PA.

21. Signature of Funeral Service Licensee ▶

22. Name and Address of Facility: Gary L. Kaufman Funeral Home at Meadowridge Pk. 7250 Washington Blvd., Elkridge, Md. 21227

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Probable Cerebrovascular Accident — Hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes

Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ▶ Michael E. [signature] MD

29c. License number: D41274

29d. Date signed *(Month, Day, Year)*: Jun 04, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael Silverman, MD Howard County General Hospital Columbia MD 21044

State Registrar

31. Date filed *(Month, Day, Year)*: JUN 06 1997

32. Registrar's Signature ▶ Julie Davidson-Randall

DHMH t6 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours in accordance with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than (natural) in Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17017

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Richard Herbert Slaughter

2. Date of Death: Month May Day 31 Year 1997

3. Time of Death: 3:50PM

4a. Facility Name (If not institution, give street and number): Anne ARundel Medical Center

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne ARundel

Funeral Director

5. Social Security Number: 232 44 6711

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 74 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jun 28 1922

9. Birthplace (State or Foreign Country): W.Va.

Usual Residence of Decedent

10a. State: Md

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 928 Mastline

10f. Zip Code: 21401

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bookbinder

16b. Kind of Business/Industry: Printing

17. Father's Name (First, Middle, Last): Burton Slaughter

18. Mother's Name (First, Middle, Maiden Surname): Rosetta Malcolm

19a. Informant's Name/Relationship (Type, Print): Kathy Fleshman/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3284 Stepney Street, Edgewater, Md 21037

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Md Veterans Cem.

Date: 6/4

20c. Location - City or Town, State: Crownville, Md

21. Signature of Funeral Service Licensee: Patrick J. Hardesty

22. Name and Address of Facility: Hardesty Funeral Home PA, 12 Ridgely Ave., Annapolis, Md 21401

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or being one of 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Respiratory Arrest

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Urosepsis

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ASCVD

COPD

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Carol Pressey

29c. License number: D25134

29d. Date signed (Month, Day, Year): June 1, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Carol Pressey M.D. 1655 Crofton Blvd. #103, Crofton, Md 21114

State Registrar

31. Date filed (Month, Day, Year): JUN 06 1997

32. Registrar's Signature: Julia Davidson-Randall

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17018

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARGARET E. SHIVE

2. Data of Daath — Month: June Day: 3 Yaer: 1997

3. Tima of Deeth: 02:00 Am

4a. Facility Neme *(If not institution, giva street and number)*: HARFORD MEMORIAL HOSPITAL

4b. City, Town, or Location of Daeth: HARFORD COUNTY

4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 216-32-1104

6. Sex: 1☐ M XX 2☐ F

7. Aga *(In yrs. last birthday)*: 85 Yrs. — If Undar 1 Year: Months / Days — If Undar 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 11, 1911

9. Birthplece *(Stata or Foreign Country)*: PA.

Usual Rasidance of Decedant

10a. Stata: Maryland

10b. County: Harford

10c. City, Town or Location: Joppatowne

10d. Insida City Limits: 1☐ Yas 2☒ No

10a. Street end Number: 813 Falconer Rd.

10f. Zip Coda: 21085

10g. Citizan of What Country?: USA

11. Maritel Status: 1☐ Nevar Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☒ No — If Yas, Giva Yeer or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1☐ Yas 2☒ No *Specify:*

14. Race - American Indian, Black, Whita, atc. *Specify:* White

15. Decedent's Education *(Spacify only highast grade compiatad)*: Elamantary/Secondary (0-12): 12 yrs. — Coliaga (1-4or 5+): 2 yrs.

16a. Decedent's Usual Occupetion *(Giva kind of work dona during most of working lifa. DO NOT usa ratired)*: Registered Nurse

16b. Kind of Businass/Industry: Union Memorial Hospital

17. Father's Nama *(First, Middla, Last)*: Joseph Kress

18. Mothar's Nama *(First, Middla, Maidan Sumama)*: Buelah M. Stitely

19a. Informant's Name/Retetionship *(Type, Print)*: Mrs. Susan Shive

19b. Mailing Addrass *(Streat and Number or Rural Routa Number, City or Town, State, Zip Code)*: 314 Roxbury Court Joppatowne, Md. 21085

20a. Mathod of Disposition: 1☐ Burial 2☒ Cremation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Placa of Disposition *(Nama of cematary, crematory or othar placa)*: Metro Crematory, Inc. — Deta: 6-3-1997

20c. Location - City or Town, Stata: Baltimore, Maryland

21. Signatura of Funeral Service Licansee

22. Nama and Addrass of Facility: E. F. Lassahn Funeral Home, 11750 Belair Rd. Kingsville, Md. 21087

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Susan Shive, Margaret Elizabeth June 3, 1997 0200

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

22a. Part I. Entar tha disaasa, or complications that caused tha daath. Do not antar the moda of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only one causa on eech lina.

Approximata Intarval Batween Onsat and Deeth

Immediate Ceuse (Final disaasa or condition resulting in deeth)

a. Cerebrovascular Accident (Intracranial Hemorrhage)

Dua to (or as a consequance of):

Sequantially list conditions, if any, leeding to immadiata cause. Entar Underlying Cause (Disaasa or injury thet initiated evants resulting in death) Last

b. Hemorrhage

Dua to (or es a consequance of):

c. Bilateral Pneumonitis

Dua to (or es a consequence of):

d.

6 days

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.: Essential Hypertension

23b. **Did tobacco use contribute to the cause of death?** 1☐ **Yes** 2☒ **No** 3☐ **Probably** 4☐ **Unknown**

24a. Wes an autopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings available prior to completion of cause of daath? 1☐ Yas 2☒ No

25. Wes casa raferred to medical axaminer? 1☐ Yas 2☒ No

26. Placa of Death *(Check only one)*: Hospital: 1☒ Inpatiant 2☐ ER/Outpatient 3☐ DOA — Othar: 4☐ Nursing Home 5☐ Rasidance 6☐ Othar *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury: M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred: Not applicable

28a. Placa of Injury - At home, farm, straat, factory, office building, atc. *(Specify)*

28f. Location *(Straat and Number or Rural Routa Number, City or Town, State)*

29a. Certifiar *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledge, daath occurrad at tha tima, data and placa, end dua to tha ceusa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at the tima, data and piace, and dua to tha causa(s) and mannar stated.

29b. Signatura and title of certifiar: MD

29c. Licansa number: D19583

29d. Data signed *(Month, Day, Year)*: June 3, 1997

30. Name and addrass of person who completed causa of death (Item 23a) (Type, Print): MANUEL M. LAZATIN MD, 8 Law St. Aberdeen, Maryland 21001

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Data filad *(Month, Day, Yeer)*: JUN 06 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

RKD
97-3017-510
JOSEPH
TILLMAN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17019

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOSEPH TILLMAN
2. Date of Death: Month JUNE Day 2 Year 1997
3. Time of Death: 5:45P.M.
4a. Facility Name (If not institution, give street and number): 1419 E.LAFAYETTE AVE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 242-54-8575
6. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthday): 58 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 1-9-39
9. Birthplace (State or Foreign Country): NorthCarolina

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Md
10b. County: N/A
10c. City, Town or Location: Balto.
10d. Inside City Limits: 1 ☑ Yes 2 ☐ No
10e. Street and Number: 1419E LAFAYETTE
10f. Zip Code: 21213
10g. Citizen of What Country?: U.S.A

11. Marital Status: 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☑ No Specify:
14. Rece - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TRUCK DRIVER
16b. Kind of Business/Industry: SEA Loin

17. Father's Name (First, Middle, Last): UN KNOWN
18. Mother's Name (First, Middle, Maiden Surname): UN KNOWN

19a. Informant's Name/Relationship (Type, Print): COUSIN SAMUEL BRANNON JR.
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1419 LAFAYETTE AVE. Balto. Md. 21213

20a. Method of Disposition: 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): METRO CREMATORY | Date: 6-5-97
20c. Location - City or Town, State: Balto. Md.

21. Signature of Funeral Service Licensee: Jeff Miller
22. Name and Address of Facility: 1639 N BROADWAY BALTO. Md 21213 JEFF MILLER P.C. FUNERAL HOME + SERVICE

Physician /Medical Examiner

23a. Part I. Enter the disease, or complicetions that ceused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Ceuse (Finel disease or condition resulting in death): e. Arteriosclerotic Cardiovascular Disease

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury thet initiated events resulting in death) Last

b. Due to (or as e consequence of):

c. Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an eutopsy performed? INSPECTION 1 ☐ Yes 2 ☒ No

24b. Were eutopsy findings available prior to completion of ceuse of death? 1 ☐ Yes 2 ☐ No

25. Was cese referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one): Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Naturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 ☐ **Certifying Phyeician:** To the best of my knowledge, death occurred et the time, dete and piece, end due to the ceuse(s) end manner as stated. 2 ☒ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, end due to the ceuse(s) and manner stated.

29b. Signeture end title of certifier
29c. License number: O.C.M.E.
29d. Date signed (Month, Dey, Year): JUNE 3, 1997

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print): DAVID R.FOWLER M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JUN 06 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed with the Vital Statistics Administration within 5 days after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "Naturel" or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1

WRC
97-2940-510
CHRISTOPHER THOMAS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17020

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CHRISTOPHER BRYAN THOMAS
2. Dete of Deeth: Month MAY Day 29, Yeer 1997
3. Time of Daeth: 10:45 AM.
4a. Feclity Name (If not institution, give street end number): SHOCK TRAUMA
4b. City, Town, or Location of Deeth: BALTIMORE
4c. County of Deeth: N/A

Funeral Director

5. Social Security Number: 220-17-4573
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 18 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): June 18, 1978
9. Birthplace (State or Foreign Country): Maryland

Usuel Residence of Decedent

10e. State: Maryland
10b. County: Harford
10c. City, Town or Location: Bel Air
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street end Number: 900 Hackberry Court
10f. Zip Code: 21014
10g. Citizen of What Country?: U.S.A.

11. Maritel Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U,S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Rece - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12th grade; College (1-4or 5+):
16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Dependant
16b. Kind of Business/Industry: N/A

17. Fathar's Name (First, Middle, Last): Terry Thomas
18. Mother's Name (First, Middle, Maiden Surneme): Joan Bryan

19a. Informant's Neme/Relationship (Typa, Print): Joan Thomas - Manley (Mother)
19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 900 Hackberry Court, Bel Air, MD. 21014

20e. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removel from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other place): Harford Memorial Gardens
Date: 5/31/97
20c. Location - City or Town, State: Aberdeen, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name end Address of Feciility: Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, MD. 21014

Physician /Medical Examiner

23e. Part1. Enter tha diseese, or complicetions that caused the death. Do not entar the mode of dying, such es cerdiac or respiretory errest, shock, or haert failura. List only one ceusa on aach lina. — Approximete Interval Between Onset end Deeth

Immediate Ceuse (Finel disease or condition resulting in deeth): e. Blunt head injuries
Due to (or es e consaquence of):
Sequentially list conditions, if eny, leading to Immediate cause. Enter Undarlying Ceuse (Diseese or injury thet initieted events resulting in death) Lest:
b. Due to (or es e consequence of):
c. Due to (or es e consequence of):
d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24e. Wes en autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were eutopsy findings eveilable prior to completion of ceuse of daeth? 1 [X] Yes 2 [ ] No

25. Wes cese refarred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only ona): Hospitel: 1 [ ] Inpatiant 2 [X] ER/Outpetient 3 [ ] DOA; Othar: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Death: 1 [ ] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28e. Data of Injury (Month, Dey Yeer): 5-25-97
28b. Time of Injury: 0050 M
28c. Injury et Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: SUBJECT STRUCK IN HEAD
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): SHOPPING MALL PARKING LOT
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete): BOX HILL SHOPPING MALL BELAIR MD.

29a. Certifier (Check only one): 1 [ ] Certifying Physicien: To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) end menner es stated. 2 [X] Medical Examinar: On the basis of axamination end/or investigation, in my opinion, death occurred et tha time, data end placa, and due to the ceuse(s) end manner stated.

29b. Signature end title of certifier: ▶ Donald G. Wright MD
29c. License number: O.C.M.E.
29d. Date signed (Month, Dey, Yeer): MAY 31, 1997

30. Nema and address of person who completed ceusa of daath (Item 23a) (Type, Print): DONALD G WRIGHT MD, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Deta filad (Month, Dey, Yeer): JUN 06 1997
32. [signature]

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" or injuries on 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

ITEM:5 per F.H G-748 6-19-97 eoh

Reg. No. 97 17021

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Anthony Thompson

2. Date of Death (Month, Day, Year): June 04, 1997

3. Time of Death: 7.08 PM.

4a. Facility Name (If not institution, give street and number): Good Samaritan Hospital

4b. City, Town, or Location of Death: Balto

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 251-215-05-5262

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Year): NOV 22, 1915

9. Birthplace (State or Foreign Country): SC

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTO

10d. Inside City Limits: ☒ Yes 2 ☐ No

10e. Street end Number: 2014 N. WASHINGTON ST

10f. Zip Code: 21213

10g. Citizen of Whet Country?: U.S.A.

11. Maritaf Status: 1 ☐ Never Merried 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indien, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): STEEL WORKER

16b. Kind of Business/Industry: STEEL CO

17. Father's Name (First, Middle, Last): TOMMY THOMPSON

18. Mother's Name (First, Middle, Meiden Surname): EUNICE SHELTON

19a. Informant's Name/Relationship (Type, Print): EUNICE JAMES

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 1201 HANDSWORTH PL BALTO, MD 21221

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Pface of Disposition (Name of cemetery, crematory or other place): THOMPSON FAMILY CEM | Date: JUNE 11 1997

20c. Location - City or Town, Stete: BLAIR, SC

21. Signature of Funeral Service Licensee: Patricia Betts

22. Name and Address of Facility: BETTS FUNERAL HOME 1129 N. CAROLINE ST BALTO, MD 21213 GIBSON FH 325 GARDEN ST WINNSBORA, SC

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximete Interval Between Onset and Death
Immediate Ceuse (Final disease or condition resulting in death) a.	Cardio Respiratory arrest.	68 minutes
Due to (or as a consequence of): b.	Aspiration	6& minutes
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet Initieted events resulting in death) Last — Due to (or es a consequence of): c.	Possible Pulmonary Embolus or	6-8 hours.
Due to (or as a consequence of): d.	Myocardial Infarction.	6-8 hours.

Part ff. **Other sfgniffcant conditions** contributing to death but not resulting in the underlying cause given fn Part I.

23b. Dfd tobacco uas contributa to the causa of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Plece of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 ☒ **Certifying Phyafcfan:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination end/or investigetion, in my opinion, death occurred at the time, dete end place, and due to the cause(a) end manner stated.

29b. Signature and title of certifier: Bryan S. Nolan M.D.

29c. License number: D25542

29d. Date signed (Month, Day, Year): June 04, 1997

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print): Bryan S. NOLAN, M.D. Good Samaritan hospital

State Registrar

31. Dete filed (Month, Day, Year): JUN 06 1997

32. Registrar's Signature: Gina Davidson-Randolph

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed with the local registrar of death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "Natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

1

WRC
97-2966-510
KEVIN
TORBIT

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17022

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Lest)*: KEVIN CARLTON TORBIT SR

2. Date of Death — Month: MAY — Dey: 31, — Yeer: 1997

3. Time of Deeth: 3:16 PM.

4e. Feclity Name *(If not institution, give street end number)*: JOHNS HOPKINS HOSPITAL E.R.

4b. City, Town, or Location of Deeth: BALTIMORE

4c. County of Deeth: N/A

Funeral Director

5. Social Security Number: 216088-6403

6. Sex: XX 1 M 2 F

7. Age *(In yrs. lest birthday)*: 27 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Yeer)*: AUG 29, 1969

9. Birthplece *(Stete or Foreign Country)*: MD

Usuel Residence of Decedent

10e. State: MD

10b. County: N/A

10c. City, Town or Location: BALTO

10d. Inside City Limits: XX 1 Yes 2 No

10e. Street end Number: 3221 LAWNVIEW AVE

10f. Zip Code: 21213

10g. Citizen of Whet Country?: U.S.A.

11. Meritel Status: 1 X Never Married 2 Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No — If Yes, Give Year or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.): 1 Yes 2 X No *Specify:*

14. Reca - American Indien, Bleck, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grede completed)*: Elementary/Secondary (0-12): 12th — College (1-4or 5+): N/A

16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: LABORER

16b. Kind of Business/Industry: PACKAGING CO

17. Fether's Neme *(First, Middle, Lest)*: JAMES TORBIT

18. Mother's Name *(First, Middle, Meiden Surneme)*: PAULETTE HOREY

19e. Informent's Neme/Relationship *(Type, Print)*: JAMES TORBIT

19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 1723 E 32ND ST BALTO, MD 21218

20a. Method of Disposition: XX 1 Burial 2 Cremation 3 Removel from State 4 Donetion 5 Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other pleca)*: MT. ZION CEM — Dete: JUNE 5 1997

20c. Location - City or Town, Stete: BALTO,MD

21. Signeture of Funerel Servica Licensee: ▶ Patricia Bass

22. Name and Address of Feclity: BET TS FUNERLA HOME 1129 N. CAROLINE ST BALTO, MD 21213

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart feilure. List only one cause on each line.

Approximete Intervel Between Onset end Death

Immediete Ceuse (Final diseese or condition resulting in deeth): e. Gunshot Wounds of Back (2)

Due to (or es e consequenca of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initieted events resulting in deeth) Lest:

b. Due to (or es e consequenca of):

c. Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 Yes 2 No 3 Probably X 4 Unknown

24e. Wes en eutopsy performed? X 1 Yes 2 No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? X 1 Yes 2 No

25. Wes case referred to medical examiner? X 1 Yes 2 No

26. Piece of Death *(Check only one)*: Hospital: 1 Inpatient X 2 ER/Outpatient 3 DOA — Other: 4 Nursing Home 5 Residence 6 Other *(Specify)*

27. Manner of Death: 1 Neturel 2 Accident 3 Suicide X 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Dete of Injury *(Month, Dey Yeer)*: 5/31/97

28b. Time of Injury: 1458 M

28c. Injury et Work? 1 Yes 2 X No

28d. Describe how injury occurred: Subject shot

28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*: Street

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*: 900 Valley Street Baltimore, Maryland

29a. Certifier *(Check only one)*: 1 **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete and plece, end due to the ceuse(s) end menner es steted. 2 X **Medical Examiner:** On the besis of exemination end/or investigation, in my opinion, death occurred et the time, date end plece, end due to the ceuse(s) and menner stated.

29b. Signeture end title of certifier: ▶ Theodore M. King

29c. License number: O.C.M.E.

29d. Dete signed *(Month, Dey, Yeer)*: JUNE 01, 1997

30. Neme and eddress of person who completed ceuse of deeth (Item 23a) (Type, Print): THEODORE M. King 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Dey, Yeer)*: JUN 06 1997

32. Registrer's Signeture: Julia Davidson-Reynolds

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed with the local registrar of death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "Neturel" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17023

Physician /Medical Examiner

1. Decadant's Name (First, Middla, Last): VINCENT ROLAND VOLPINI

2. Data of Daath: Month JUNE Day 01, Year 1997

3. Tima of Deeth: 6:45 PM

4a. Facility Nama (If not institution, giva street and number): Saint Joseph Medical Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Sacurity Number: 218 28 6505

6. Sax: ☒ M 2☐ F

7. Aga (In yrs. last birthday): 65 Yrs.

If Undar 1 Yaar: Months / Days

If Undar 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): MARCH 3 1932

9. Birthplace (Stata or Foreign Country): MARYLAND

Usual Rasidance of Decadant

10a. Stata: MARYLAND

10b. County: BALTIMORE

10c. City, Town or Location: GLEN ARM

10d. Insida City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 10824 FACTORY ROAD

10f. Zip Coda: 21057

10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1☒ Navar Marriad 2☐ Marriad 3☐ Widowad 4☐ Divorcad

12. Was Decadant Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No. If Yas, Giva Yaar or Datas:

13. Was Decadant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.): 1☐ Yas 2☒ No Specify:

14. Race - Amarican Indian, Black, Whita, atc. Specify: WHITE

15. Decadant's Education (Specify only highast grada complatad): Elementary/Secondary (0-12): 9YRS. College (1-4or 5+):

16a. Decadant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratirad): RECEIVER + SHIPPER

16b. Kind of Business/Industry: BETHLEHEM STEEL

17. Fathar's Name (First, Middla, Last): SABATINE VOLPINI

18. Mothar's Name (First, Middla, Maidan Sumama): LOUISA COLATI

19a. Informant's Name/Relationship (Type, Print): ALBINA V. PETERSON

19b. Mailing Address (Strat and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 10824 FACTORY ROAD GLEN ARM MARYLAND 21057

20a. Method of Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)

20b. Place of Disposition (Nama of cematary, crematory or other place): EVANS FUNERAL CHAPEL — BEL AIR, P.A.

Data: JUNE 3 1997

20c. Location - City or Town, Stata: FOREST HILL, MARYLAND

21. Signatura of Funaral Sarvica Licansaa: [signature]

22. Nama and Addrass of Facility: EVANS FUNERAL CHAPEL — BEL AIR, P.A. 3 NEWPORT DRIVE FOREST HILL MARYLAND 21050

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only ona causa on aach lina.

Approximata Intarval Batween Onsat and Death

Immediata Cause (Final disaasa or condition resulting in daath): e. LUNG CANCER

Due to (or as a consequanca of):

Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that initiatad avants rasulting in daath) Last:

b. MYOCARDIAL INFARCTION

Dua to (or as a consequanca of):

c. MALIGNANT PLEURAL EFFUSION

Dua to (or as a consequanca of):

d.

Part II. **Othar significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco usa contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Ware autopsy findings available prior to compilation of cause of death? 1☐ Yas 2☐ No

25. Was casa rafarrad to medical exeminar? 1☐ Yas 2☒ No

26. Placa of Death (Check only ona): Hospital: 1☒ Inpatiant 2☐ ER/Outpatiant 3☐ DOA Othar: 4☐ Nursing Hama 5☐ Rasidanca 6☐ Othar (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarminad

28a. Data of Injury (Month, Day Yaar)

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurrad

28e. Place of Injury - At homa, farm, straat, factory, office building, etc. (Spacify)

28f. Location (Straat and Number or Rural Routa Number, City or Town, State)

29a. Cartifiar (Check only one): ☒ **Certifying Physician**: To tha best of my knowladga, daath occurrad at tha tima, data and placa, and dua to tha cause(s) and manner as stated. ☐ **Medical Examinar**: On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and due to the causa(s) and mannar stated.

29b. Signatura and titla of certifiar: Jogindar P Mehta MD

29c. Licansa number: D41410

29d. Data signed (Month, Day, Year): June 2nd, 1997

30. Nama and addrass of parson who complatad causa of daath (Itam 23a) (Typa, Print): JORGINDER P. MEHTA, M.D 7620 YORK ROAD TOWSON, MARYLAND 21204

State Registrar

31. Data filad (Month, Day, Year): JUN 06 1997

32. Registrar's Signatura: Lidia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or if item 23a of 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 17024

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lillian O. Vaughn
2. Dete of Death (Month, Dey, Yeer): June 2, 1997
3. Time of Death: 4:00 AM
4e. Facility Name (If not institution, give street end number): 3320 Tate Street
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

Funeral Director

5. Social Security Number: 218-42-3579
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 97 Yrs.
If Under 1 Year: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Yeer): 11-23-1899
9. Birthplace (Stete or Foreign Country): S.C.
Usuel Residence of Decedent
10a. Steta: Md
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 3318 Tate Street
10f. Zip Code: 21216
10g. Citizan of Whet Country?: U.S.A
11. Marital Stetus: 1☐ Navar Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Bieck, White, etc. Specify: Black
15. Decadent's Education (Specify only highest grada completed)
Elemantary/Secondary (0-12): 10th grade
College (1-4or 5+): NA
16e. Decedent's Usual Occupetion (Give kind of work done during most of working lifa. DO NOT use retired): Housewife
16b. Kind of Business/Industry: Home
17. Father's Nema (First, Middle, Last): John McCullough
18. Mother's Name (First, Middle, Meiden Surneme): Mary Jane Anderson
19e. Informent's Neme/Reletionship (Type, Print): Edward Vaughn-Son
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 3412 Tulsa Road 21207
20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Woodlawn Cem
Dete: 6-6-97
20c. Location - City or Town, Stete: Baltimore, Md
21. Signature of Funerel Service Licensee: Gabrielle Cook
22. Name and Address of Facility: Mack F. H. West 4300 Wabash Avenue Balto, Md 21215

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part1. Enter tha disaasa, or complications that caused the daath. Do not entar tha moda of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximeta Interval Between Onset end Deth

Immediete Cause (Final disaasa or condition resulting in deeth): a. Arteriosclerotic Cardiovascular Disease

Due to (or es a consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest

b.

Due to (or es e consequence of):

c.

Due to (or es e consequenca of):

d.

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

23b. Did tobacco uee contribute to the causa of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings availeble prior to completion of causa of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Piece of Deeth (Check only one) Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residenca 6☐ Other (Specify)

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) and menner es stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, date end piece, and due to the ceuse(s) end menner steted.

29b. Signature and title of certifier: Jorge Vallecillo

29c. Licensa number: D26203

29d. Date signad (Month, Day, Yeer): 6/05/97

30. Nema and address of person who completed cause of death (Item 23e) (Type, Print): Jorge Vallecillo, M.D. 1319 Light St Baltimore 21230

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

31. Dete filed (Month, Dey, Yeer): JUN 06 1997

32. Registrer's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17025

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GEORGE E. VIERECK
2. Date of Death: Month May, Day 30, Year 1997
3. Time of Death: 9:10PM
4a. Facility Name (If not institution, give street and number): Suburban Hospital
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 265-14-1295
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): April 1, 1909
9. Birthplace (State or Foreign Country): Ohio

Usual Residence of Decedent

10a. State: Virginia
10b. County: Fairfax
10c. City, Town or Location: McLean
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 8380 Greensboro Drive, Apt 1026
10f. Zip Code: 22102
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): Collega (1-4or 5+): 4+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Representative
16b. Kind of Business/Industry: Machinery Tools

17. Father's Name (First, Middle, Last): Frank Viereck
18. Mother's Name (First, Middle, Maiden Surname): (FN Unknown) Richter

19a. Informant's Name/Relationship (Type, Print): Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8380 Greensboro Dr.,Apt.1026, McLean, Va. 22102

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory
Date:
20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: MONEY & KING VIENNA FUNERAL HOME,INC. 171 W. Maple Ave., Vienna, Va. 22180

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Acute myocardial infarction — 36h
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Atherosclerotic cardiovascular disease
Due to (or as a consequence of):
c. Hypertension
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Chronic obstructive pulmonary disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one) — Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28b. Time of Injury: M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Date of Injury (Month, Day Year)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Samuel D. Goldberg MD
29c. License number: 16360
29d. Date signed (Month, Day, Year): 5/31/97
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Samuel D. Goldberg MD 6410 Rockledge Dr. Bethesda, MD 20817

State Registrar

31. Date filed (Month, Day, Year): JUN 06 1997
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 10 days after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17026

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ethel W. Wrede
2. Deta of Death — Month: June Day: 5 Year: 1997
3. Tima of Death: 4:30AM
4a. Facility Name (If not institution, give street end number): Holly Hill Manor
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-05-2325
6. Sax: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 93 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Year): July 10, 1903
9. Birthplaca (State or Foreign Country): Maryland

Usual Restdence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Parkville
10d. Inside City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 9018 Hines Rd.
10f. Zip Code: 21234
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Evar in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexicen, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, atc. Specify: White

15. Decedent's Educetion (Specify only highest grade completed): Elementary/Secondary (0-12): 8 YRS. College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Home

17. Father's Neme (First, Middle, Last): unknown Brewer
18. Mother's Name (First, Middle, Maiden Surneme): unknown

19a. Informant's Name/Relationship (Type, Print): D. Joy Heaps grand daughter
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 8503 Willow Oak Rd. Baltimore, Md 21234

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Dulaney Valley Memorial Gardens — Date: June 9 1997
20c. Location - City or Town, State: Timonium, Maryland

21. Signature of Funeral Service Licensee: Krista S. Wells
22. Nama and Address of Facility: Evans Chapel of Memories 8800 Harford Rd. Baltimore, Md 21234

Physician /Medical Examiner

23a. Part1. Enter the disaase, or complications that caused tha death. Do not entar tha mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on aach line.

Approximate Intervel Batween Onset and Deeth

Immediate Cause (Finat disease or condition resulting in death): e. Coronary artery disease — 4 years

Due to (or as a consequenca of):

Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequance of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.: Congestive heart failure

23b. Did tobacco usa contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings available prior to completion of causa of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Piece of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28e. Piaca of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. 2☐ **Medicat Examiner:** On the basis of examtnation and/or investigetion, in my opinton, death occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: Marc D. Sokolow Attending Physician
29c. Licansa number: D26534
29d. Date signed (Month, Dey, Year): 6/5/97

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): DR. Marc D. Sokolow 301 Saint Paul Pl. Baltimore, MD 21202

State Registrar

31. Date filed (Month, Dey, Year): JUN 06 1997
32. Regts'ar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", complete 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17027

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Jewell Theus Wise

2. Data of Death Month Day Year: June 4, 1997

3. Time of Death: 11:30 A.M.

4a. Facility Name *(If not institution, give street and number)*: Baptist Home of Maryland

4b. City, Town, or Location of Death: Owings Mills

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 465-46-1709

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 83 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: Aug. 30, 1913

9. Birthplace *(State or Foraign Country)*: Oklahoma

Usual Rasidance of Dacedent

10a. Stata: Maryland

10b. County: Baltimore

10c. City, Town or Location: Owings Mills

10d. Insida City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 10729 Park Heights Avenue

10f. Zip Code: 21117

10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1☐ Navar Marriad 2☐ Marriad 3☒ Widowad 4☐ Divorcad

12. Was Dacedant Evar in U,S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Give Yaar or Datas:

13. Was Dacedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yas 2☒ No *Specify:*

14. Race - Amarican Indian, Black, Whita, atc. *Specify:* White

15. Decedant's Education *(Specify only highast grada complatad)*: Elamantary/Secondary (0-12): 12 Years; Coliaga (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retired)*: Cafeteria Worker

16b. Kind of Businass/Industry: El Paso, Texas Public Schools

17. Fathar's Nama *(First, Middla, Last)*: William Judson Fuller

18. Mothar's Nama *(First, Middla, Maidan Surnama)*: Annie Ledbetter

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Jeanette Anne Casey

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, State, Zip Code)*: 10719 Lancewood Road Hunt Valley, MD 21030

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Spacify)*

20b. Place of Disposition *(Nama of camatary, cramatory or othar place)*: Fort Bliss National Cem

Data: 6/9

20c. Location - City or Town, State: El Paso, Texas

21. Signeture of Funaral Service Licensee:

22. Nama and Address of Facility: Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133

Physician /Medical Examiner

23a. Part I. Enter the diaasse, or complicetions that ceused the deeth. Do not antar tha mode of dying, such es cardiec or respiretory errest, shock, or heart failura. List only one cause on aach lina.

Approximata Intarval Betwaen Onsat and Death

Immedieta Causa (Final diseasa or condition rasulting in death): e. central fever of 106° — 3 days

Dua to (or as a consaquanca of): b. brain metastasis — ~3 months

Sequentiatly list conditions, if any, laading to immadiata causa. Entar Undarlying Ceuse (Diseasa or injury thet initiated avents rasulting in daath) Last

Due to (or as a consequence of): c. breast cancer — 2 years

Dua to (or as a consequence of): d.

Part II. **Othar significant conditions** contributing to daath but not rasulting in tha underlying causa givan in Part I.: HTN, NIDDM, obesity, hypercholesterol

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☑ No

24b. Ware autopsy findings availeble prior to complation of cause of death? 1☐ Yes 2☑ No

25. Was cesa rafarrad to medical axaminer? 1☐ Yas 2☑ No

26. Placa of Daath *(Chack only ona)*: Hospital: 1☐ Inpetient 2☐ ER/Outpatient 3☐ DOA; Other: 4☑ Nursing Homa 5☐ Rasidance 6☐ Othar *(Specify)*

27. Manner of Death: 1☑ Naturei 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding investigation 6☐ Could not ba determined

28a. Dete of injury *(Month, Day Year)*: N/A

28b. Time of injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Dascribe how injury occurred

28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. *(Specify)*: N/A

28f. Location *(Street and Number or Rural Routa Number, City or Town, State)*

29a. Cartifiar *(Check only one)*: 1☑ **Certifying Phyaician:** To tha best of my knowledge, daeth occurrad at tha time, date and plece, end dua to the ceuse(s) end mannar as statad. 2☐ **Madical Exsminer:** On tha basis of examination and/or investigation, in my opinion, daath occurrad at tha time, data and place, and dua to the ceusa(s) and mennar statad.

29b. Signature end titia of certifier:

29c. Licensa number: D41104

29d. Data signed *(Month, Day, Year)*: 6.4.97

30. Nama and address of parson who compiatad causa of deeth (itam 23e) (Typa, Print): Ted Houk 7825 York Road Towson MD 21204

State Registrar

31. Date filed *(Month, Day, Year)*: JUN 06 1997

32. Registrar's Signatura: Julia Davidson-Randall

DHMH 16 Rav 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours in accordance with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," sections 23a or 28a-f show any injury or other traumatic event, the Medical Examiner/Coroner is notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

97-2958-003
CIP
UNKNOWN 97-119 RAYMOND WAGSTAFF

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17028

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RAYMOND WAGSTAFF-EL

2. Dete of Death (Month, Day, Year): MAY 30, 1997

3. Time of Deeth: 9:59PM

4a. Facility Neme (If not institution, give street and number): ANNE ARUNDEL GENERAL HOSPITAL

4b. Cify, Town, or Location of Death: ANNAPOLIS

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: UNK

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 42 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb 18,1955

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md | 10b. County: N/A | 10c. City, Town or Location: Baltimore | 10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 2926 Westwood Avenue | 10f. Zip Code: 21216 | 10g. Citizen of What Country?: USA

11. Maritai Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decadent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+): 3 yrs

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Paralegal

16b. Kind of Business/Industry: Legal

17. Father's Name (First, Middle, Last): Herman L. Mitchell Jr.

18. Mother's Name (First, Middle, Meiden Surneme): Mary Wagstaff

19a. Informant's Name/Relationship (Type, Print): Rebecca Tartley (Aunt)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2916 Westwood Ave. Baltimore, Md 21216

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion Cem | Date: 06/07/97

20c. Location - City or Town, State: Lansdowne, Md

21. Signature of Funeral Service Licensee: Donna B. Cole

22. Name end Address of Faciiity: Caple Funeral Service 5502 Winner Avenue Baltimore, Md 21215

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiiure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death): a. Multiple gunshot wounds

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in deeth) Lest

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other aignificant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings aveilable prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medicai examiner? 1 [X] Yes 2 [ ] No

26. Piace of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year): 5-30-97

28b. Time of injury: 2115 M

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: SUBJECT SHOT BY POLICE

28e. Piace of Injury - At home, farm, street, factory, office building, etc. (Specify): SHOPPING MALL

28f. Location (Street and Number or Rural Route Number, City or Town, State): ANNAPOLIS MALL ANNAPOLIS, ANNE ARUNDEL CO, MD

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowiedge, deeth occurred at the time, date end piace, end due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete end piace, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Donald G. Wright MD

29c. License number: O.C.M.E.

29d. Date signed (Month, Dey, Year): MAY 31, 1997

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print): DONALD G. WRIGHT MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JUN 06 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17029

Physician /Medical Examiner

1. Decedent's Nama *(First, Middle, Last)*: Virginia C. Wheeler

2. Data of Deeth — Month: May, Day: 31, Yaar: 1997

3. Time of Death: 5:26 P.M.

4a. Facility Nama *(If not institution, give straet and number)*: Genesis Eldercare

4b. City, Town, or Location of Daath: Severna Park

4c. County of Death: Anne Arundel

Funeral Director

5. Social Sacurity Number: 219-16-9547

6. Sax: 1☐ M 2☒ F

7. Aga *(In yrs. last birthday)*: 84 Yrs.

If Under 1 Yaar — Months: Days: If Under 24 Hrs. — Hours: Min.:

8. Data of Birth *(Month, Day, Year)*: March 4, 1913

9. Birthplaca *(State or Foreign Country)*: Maryland

Usual Rasidance of Dacedant

10a. Stete: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Glen Burnie

10d. Insida City Limits: 1☐ Yas 2☒ No

10e. Street and Numbar: 1210 Wilson Rd.

10f. Zip Coda: 21061

10g. Citizan of What Country?: United States

11. Marital Stetus: 1☐ Navar Marriad 2☐ Married 3☒ Widowed 4☐ Divorcad

12. Was Decedant Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Give Yaer or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 1☐ Yas 2☒ No *Specify:*

14. Race - American Indian, Black, White, atc. *Specify:* White

15. Decedant's Educetion *(Specify only highast grada complatad)*: Elementary/Secondary (0-12): 10; Collaga (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work done during most of working lifa. DO NOT usa ratirad)*: Sales

16b. Kind of Businass/Industry: Retail

17. Father's Nama *(First, Middla, Last)*: John Sheckells

18. Mothar's Nama *(First, Middla, Maidan Surnama)*: Emma Coleman

19a. Informant's Name/Ralationship *(Type, Print)*: Joan E. Bissett / Daughter

19b. Mailing Address *(Straat and Numbar or Rural Routa Numbar, City or Town, Stata, Zip Coda)*: 306B Gatehouse Lane, Odenton, Maryland 21113

20a. Mathod of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Ramovel from Stata 4☐ Donation 5☐ Other *(Spacify)*

20b. Place of Disposition *(Nama of cemetery, cramatory or othar place)*: Glen Haven Mem. Pk.

Data: June 3, 1997

20c. Location - City or Town, Stata: Glen Burnie, Maryland

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility: Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, MD 21061

Physician /Medical Examiner

23a. Part1. Enter tha diseesa, or complications that caused the daath. Do not antar tha mode of dying, such as cardiec or respiretory errast, shock, or haart failure. List only ona causa on each lina.

		Approximate Interval Batween Onset and Deeth
Immediate Causa (Final disaasa or condition resulting in death) a.	Pneumonia	48hours
Due to (or as a consequence of): b.	Congestive Heart Failure	10years
Sequantially list conditions, if any, leading to immadiata ceuse. Entar Underlying Causa (Disaasa or Injury that Initiated events resulting in daath) Last — Due to (or as a consequence of): c.	Arteriosclerotic Cardiovascular Disease	10years
Due to (or as a consequence of): d.	Osteoarthritis	20years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa givan in Part I.

23b. Did tobacco use contribute to the ceuse of death? 1☐ Yee 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings aveilable prior to compiation of causa of daath? 1☐ Yas 2☑ No

25. Was casa rafarred to medical examinar? 1☐ Yas 2☒ No

26. Place of Death *(Check only ona)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA; Othar: 4☒ Nursing Homa 5☐ Rasidance 6☐ Othar *(Specify)*

27. Manner of Daath: 1☒ Natural 2☐ Accidant 3☐ Sulcide 4☐ Homicide 5☐ Panding invastigation 6☐ Could not be datarmined

28a. Date of Injury *(Month, Day Yaar)*:

28b. Tima of Injury:

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred:

28e. Place of Injury - At homa, farm, streat, factory, office building, atc. *(Spacify)*:

28f. Location *(Street and Number or Rural Routa Number, City or Town, State)*:

29a. Cartifiar *(Check only one)*: 1☑ **Certifying Physician**: To tha best of my knowledga, daath occurrad at tha tima, data and place, and dua to the causa(s) and mannar as statad. 2☐ **Medical Examinar**: On tha basis of examination and/or invastigation, in my opinion, daath occurred at tha time, data and place, and dua to the causa(s) and mannar stated.

29b. Signature and Title of certifier ▶ Elliott Gorbaty

29c. Licansa number: D20094

29d. Date signed *(Month, Day, Year)*: June 1, 1997

30. Name and address of person who completed ceuse of daath (Item 23a) (Typa, Print): Elliott Gorbaty, M.D., 7845 Oakwood Rd., Glen Burnie, Maryland 21061

State Registrar

31. Data filad *(Month, Day, Year)*: JUN 06 1997

32. Registrar's Signature ▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed with the local registrar of death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than natural, or if items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17030

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JAMES L WATKINS
2. Data of Death Month 05 Day 29 Year 97
3. Time of Death 8:45 pm
4a. Facility Name (If not institution, give street and number): 1835 E. BALTIMORE St
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-16-6187
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 74 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 8-10-22
9. Birthplace (State or Foreign Country): VA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Md
10b. County: N A
10c. City, Town or Location: Balto.
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1835 E. Baltimore St
10f. Zip Code: 21231
10g. Citizen of What Country? U.S.A

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1/1/43 - 12/17/45
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):
18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Custodian
16b. Kind of Business/Industry: Balto City School
17. Father's Name (First, Middle, Last): EDWARD WATKINS
18. Mother's Name (First, Middle, Maiden Surname): CARRIE JONES
19a. Informant's Name/Relationship (Type, Print): MARGARET WATKINS
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1835 E. BALTO. ST BALTO. Md 21231
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Lorraine Forest Cem.
Date: 6/3/97
20c. Location - City or Town, State: Owings Mills, Md
21. Signature of Funeral Service Licensee: Joseph L. Locke, Jr.
22. Name and Address of Facility: Locke Funeral Home 1304 N. Central Ave Balto Md

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Prostate Cancer — 5 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Hypertension

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one)
Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Gregory W. Branch, MD
29c. License number: 046194
29d. Date signed (Month, Day, Year): 6/5/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gregory W. Branch 1000 E. Eager Street Baltimore 21202

State Registrar

31. Date filed (Month, Day, Year): JUN 06 1997
32. Registrar's Signature: Julia Davidson-Randall

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural," cases for 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

10

DHMH 16 Rev 6/95

97-2988-011
CMK
DAVID B. WILLIAMS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17031

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: David B. Williams
2. Date of Death Month Day Year: JUNE 01, 1997
3. Time of Death: 2136PM
4a. Facility Neme *(If not institution, give street and number)*: ROUTE 404 AT ROUTE 480-ROADWAY
4b. City, Town, or Locafion of Death: HILLSBORO
4c. County of Deafh: CAROLINE COUNTY

Funeral Director

5. Social Security Number: 213-94-7661
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 32 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Day, Year)*: Aug.1,1964
9. Birthplace *(State or Foreign Country)*: Connecticut

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Annapolis
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Streef and Number: 1110 Hoover Street
10f. Zip Code: 21403
10g. Citizen of Whaf Country?: USA

11. Marifel Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedenf Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedenf of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Welder
16b. Kind of Business/Industry: Welding

17. Fether's Neme *(First, Middle, Last)*: George David Williams
18. Mother's Name *(First, Middle, Maiden Surname)*: Shirley Virginia Bryan

19e. Informent's Name/Relationship *(Type, Print)*: Linda D. Black - SISTER
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1354 Black Walnut Ct. Annapolis, MD 21401

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremafion 3 [ ] Removal from State 4 [ ] Donefion 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory — Date: 6/5
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Patrick J Arnold
22. Name and Address of Facility: Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicafions that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Intervel Between Onset and Death

Immediate Cause (Finel disease or condition resulting in deeth): a. MULTIPLE INJURIES
Due to (or as a consequence of):
Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in deeth) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part fI. **Other aignificant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cauae of death?** 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings eveileble prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other *(Specify)* AT SCENE

27. Manner of Deeth: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*: 6 1 97
28b. Time of Injury: 2021 M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: DRIVER IN IMPACT WITH ANOTHER VEHICLE
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: ROADWAY
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: RT480 CAROLINE CO. MARYLAND

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Phyaician**: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) and manner as stated. 2 [X] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and menner stated.
29b. Signature and title of certifier: Maryann Bochnik
29c. License number: O.C.M.E.
29d. Date signed *(Month, Day, Year)*: JUNE 02, 1997
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARYANN BOCHNIK 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JUN 06 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural" or if item 28a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, **To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17032

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Eugenia Allen

2. Data of Death — Month: June; Dey: 5; Year: 1997

3. Time of Death: 0659

4e. Facility Nema *(If not institution, giva street and number)*: Sinai Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: NA

Funeral Director

5. Socie1 Security Number: 216-36-8049

6. Sax: 1☐ M 2☑ F

7. Age *(In yrs. lest birthday)*: 89 Yrs.

If Under 1 Yeer — Months: ; Days:

If Under 24 Hrs. — Hours: ; Min.:

8. Dete of Birth *(Month, Day, Year)*: JAN. 10, 1908

9. Birthplece *(Stata or Foreign Country)*: S.C.

Usual Rasidance of Dacedant

10a. Steta: Md

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☑ Yes 2☐ No

10a. Street and Number: 2535 Loyola Northway

10f. Zip Coda: 21215

10g. Citizan of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☑ Divorced

12. Was Decedant Evar in U.S. Armed Forcas? 1☐ Yas 2☑ No — If Yas, Giva Yeer or Detas:

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxicen, Puarto Ricen, atc.): 1☐ Yas 2☑ No *Specify:*

14. Rece - American Indien, Black, Whita, etc. *Specify:* Black

15. Decedant's Educetion *(Specify only highest grada completed)*

Elamentary/Secondary (0-12): 12th

College (1-4or 5+): NA

16a. Decedant's Usual Occupation *(Give kind of work done during most of working lifa. DO NOT usa ratired)*: L.P.N.

16b. Kind of Business/Industry: Hospital

17. Fathar's Nama *(First, Middle, Last)*: EDDIE Hicks

18. Mothar'a Nama *(First, Middle, Maidan Sumame)*: EUGENIA WRIGHT

19a. Informant's Name/Reletionship *(Type, Print)*: Willa T. Walker-Daughter

19b. Meiling Address *(Streat and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda)*: 2535 Loyola Northway Balto Md. 21215

20a. Mathod of Disposition: 1☑ Burial 2☐ Cremation 3☐ Ramovel from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Nama of cematary, cramatory or othar place)*: Woodlawn Cemetery

Data: 6.11.97

20c. Location - City or Town, Stata: Balto. Md

21. Signature of Funaral Sarvice Licensee: Glynn B Harris

22. Name and Address of Facility: March F.A. West 4300 Wabash Avenue Balto, Md 21215

Physician /Medical Examiner

23e. Pert1. Entar tha diseasa, or complications that ceusad tha daath. Do not antar tha moda of dying, such as cerdiac or raspiratory errast, shock, or haart failura. List only ona ceusa on aach line.

Approximate Interval Batwaan Onset end Deeth

Immediete Ceusa (Final disaasa or condition rasulting in daath)

e. Myocardial infarction — Approximate Interval: 2 hours

Dua to (or as a consequance of):

Sequentially list conditions, if any, leeding to immadiata ceuse. Enter Underlying Causa (Diseasa or Injury thet Initiated evants rasulting in death) Last

b. IHSCVD

Dua to (or es e consequance of):

c.

Dua to (or as a consaquance of):

d.

Part II. **Other significant conditions** contributing to daath but not rasulting in tha undarlying ceusa givan in Part I.

CVA

Diabetes

COPD

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performad? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yas 2☐ No

25. Was cesa rafarred to medical examinar? 1☐ Yas 2☑ No

26. Placa of Daath *(Check only one)*

Hospitel: 1☐ Inpatiant 2☑ ER/Outpatient 3☐ DOA

Othar: 4☐ Nursing Homa 5☐ Residance 8☐ Other *(Specify)*

27. Manner of Death: 1☑ Neturel 2☐ Accidant 3☐ Suicida 4☐ Homicide 5☐ Panding investigation 6☐ Could not ba datarminad

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Place of Injury - At homa, farm, straat, factory, offica building, etc. *(Specify)*

28f. Location *(Straat and Number or Rurel Route Number, City or Town, Stata)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifiar *(Check only one)*: 1☑ **Certifying Phyaician:** To tha best of my knowledga, daath occurrad at tha tima, data and place, and dua to the ceuse(s) end manner as stated. 2☐ **Medical Examiner:** On tha basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the ceuse(s) and mannar stated.

29b. Signature and title of certifier:

29c. License number: D27569

29d. Data signed *(Month, Day, Year)*: 6/6/97

30. Name and eddress of person who completed causa of daath (Item 23e) (Type, Print): Allen Heffleman 1838 Greene Tree Rd #300

State Registrar

31. Date filed *(Month, Day, Year)*: JUN 09 1997

32. Registrar's Signeture: Julia Davidson-Randall

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", "accident" or "suicide" or 28d-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17033

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Anna E. Ahrens

2. Date of Death Month Day Year: June 5, 1997

3. Time of Death: 11:25 AM

4a. Facility Name (If not institution, give street and number): Carroll County General Hospital

4b. City, Town, or Location of Death: Westminister

4c. County of Death: Carroll County

Funeral Director

5. Social Security Number: 219-16-6578

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 72 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 28, 1924

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Dundalk

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2865 Plainfield Road

10f. Zip Code: 21222

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 11 Years

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk

16b. Kind of Business/Industry: Hospital

17. Father's Name (First, Middle, Last): Maurice Knauer

18. Mother's Name (First, Middle, Maiden Surname): Anna Rothlingshofer

19a. Informant's Name/Relationship (Type, Print): Henry Ahrens/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2865 Plainfield Road Dundalk, Maryland 21222

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Gdns of Faith Cemetery

Date: 6/9/1997

20c. Location - City or Town, State: Rossville, MD

21. Signature of Funeral Service Licensee: Chad M. Ruck

22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. METASTATIC MELANOMA — 15 yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Flavio Kruter MD

29c. License number: D35398

29d. Date signed (Month, Day, Year): 6/5/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Flavio Kruter. MD - 684A Poole Rd - Westminster, MD 21157

State Registrar

31. Date filed (Month, Day, Year): JUN 09 1997

32. Registrar's Signature: Linda Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be completed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other trauma, then the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 | 7034

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EDNA AFFELDT
2. Date of Death Month/Day/Year: JUNE 8, 1997
3. Time of Death: 05:45 PM
4a. Facility Name (If not institution, give street and number): Saint Joseph Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 163-30-1426
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 87 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 01, 1909
9. Birthplace (State or Foreign Country): Avoca, Pa.

Usual Residence of Decedent

10a. State: Pa.
10b. County: Luzerne
10c. City, Town or Location: Swoyersville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 29 McHale Street
10f. Zip Code: 18704
10g. Citizen of What Country?: United States

11. Maritel Stetus: 1☐ Navar Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedenf Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaer or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Bleck, Whlte, atc. Specify: White

15. Decedent's Education (Specify only highest grada completed): Elementery/Secondery (0-12): 09; College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Home Maker
16b. Kind of Business/Industry: Own Home

17. Fether's Name (First, Middle, Last): Anthony Soy
18. Mother's Name (First, Middle, Meidan Sumame): Agnes Piechota

19a. Informent's Name/Relationship (Type, Print): Mrs. Agnes B. Romonko (Daughter)
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 1027 Marleigh Circle Towson, Maryland 21204

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Othar (Specify)
20b. Plece of Disposition (Name of cemetery, crematory or other piece): Holy Name/St. Mary's Cem.
Dete: 6/09/97
20c. Location - City or Town, Stete: Swoyersville, Pa.

21. Signeture of Funeral Service Licensee: Jeffrey L. Gair
22. Name end Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md.21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complicetions thet causad the death. Do not enter tha mode of dying, such es cardiac or raspiratory arrest, shock, or heert failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediete Ceuse (Final disease or condition resulting in death) a.	METABOLIC ACIDOSIS	48 HOURS
Due to (or es a consequence of):	CANDIDA ALBICANS SEPTICEMIA	5 DAYS
Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury thet Initieted events resulting in deeth) Last b.	RENAL FAILURE	5 DAYS
Due to (or as e consequenca of):	(BACTERIAL) PYELONEPHRITIS	20 DAYS
d.		

Part II. **Other eignificant conditiona** contributing to death but not resulting in the underlying cause given in Part I.

ATRIAL FIBRILATION

CEREBROVASCULAR ACCIDENT

23b. Did tobacco use contribute to the cause of death? 1☐ Yee 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings eveliebla prior to completion of causa of deeth? 1☐ Yes 2☒ No

25. Wes case referred to medicai exeminer? 1☐ Yes 2☒ No

26. Plece of Deeth (Check only one): Hospital: 1☒ inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Homa 5☐ Residence 6☐ Othar (Specify)

27. Menner ot Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete ot Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end pleca, end due to the cause(s) end menner steted.

29b. Signature and title of certifier: Serena Nolan MD
29c. License number: D 25010
29d. Date signed (Month, Day, Year): 6/7/97

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print): SERENA NOLAN, M.D., 7620 YORK ROAD TOWSON, MARYLAND 21204

State Registrar

31. Date filed (Month, Dey, Yeer): JUN 0 9 1997
32. Registrer's Signeture: Linda Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than natural, items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

97-3132-510
CIP
MELVIN BOULDIN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17035

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Melvin R. Bouldin
2. Date of Death (Month, Day, Yeer): JUNE 3, 1997
3. Time of Death: 11:47AM
4a. Facility Neme (If not institution, give street and number): JOHNS HOPKINS HOSPITAL
4b. City, Town, or Location of Deeth: BALTIMORE
4c. County of Death: N.A

Funeral Director

5. Social Security Number: 218 12 3995
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 69 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 5/6/28
9. Birthplace (State or Foreign Country): Md

To Be Completed by Funeral Director

Usual Residence of Decadent

10e. Stete: Md
10b. County: N.A.
10c. City, Town or Location: Balto.
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2736 Mura St
10f. Zip Code: 21213
10g. Citizen of What Country?: U.S.A

11. Maritel Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Wes Decadent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): WAREHOUSMAN
16b. Kind of Business/Industry: Aberdeen Proving Grounds
17. Father's Neme (First, Middle, Last): Moses Moody
18. Mother's Name (First, Middle, Malden Surname): Genevieve Bouldin
19a. Informent's Name/Relationship (Type, Print): Patricia Bouldin
19b. Malling Addreas (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3600 Labrinth Rd Apt 21 Balto. Md 21215
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Placa of Disposition (Name of cemetery, crematory or other placa): Mt Zion Cem. Date: 6/9/97
20c. Location - City or Town, Stete: Landowncs Md
21. Signature of Funeral Service Licensee: Joseph B. Locke Jr
22. Name and Address of Facility: Locke Funeral Home 1304 N. Central Ave Balto. Md

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed [illegible] death with the Maryland Department of Health and Mental Hygiene, Vital Records. If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset end Death

Immediate Cause (Finel disease or condition resulting in death): e. Arteriosclerotic Cardiovascular Disease
Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet Initieted events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other elgnificent conditlone** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes en autopsy performed? INSPECTED 1☐ Yes 2☒ No
24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☒ Yes 2☐ No
26. Piece of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and piece, end due to the ceuse(s) and manner as stated. 2☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.
29b. Signature and title of certifier: John E. Smialek MD
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): JUNE 9, 1997
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOHN E. SMIALEK M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Day, Year): JUN 0 9 1997
32. Registrar's Signature: Julia Davidson-Randall

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Item8 6-9-97 FilmG748 W.H.Per F/H

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17036

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Adell		Brown	June	5,	1997	2:40 A.M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Caton Manor N/H.	Baltimore	NA

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Data of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-22-2159	1☐ M 2☑ F	83 Yrs.			July 6, 1913	S.C.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	NA	BALTIMORE	1☑ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1704 N. Monroe St.	21217	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced	1☐ Yes 2☑ No If Yes, Give Year or Dates:	1☐ Yes 2☑ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th	NA	Cook	Unknown

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Isaiah Carryall	Josephine English

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Elsie Carryall - Daugh. N-law	2302 Wichita Ave. Balto. MD 21215

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Arbutus Mem. Park	6-9-97	Arbutus, Md

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Glynnis B. Harris	March F H West 4300 Wabash Avenue Balto, Md 21215

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "Natural," pending 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ACUTE MYOCARDIAL INFARCTION	MINUTES
	Due to (or as a consequence of): ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE	Years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown	1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Surjit Jutla	D 26395	6/5/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
821 N. Eutaw St. Suit 407 Baltimore MD 21201 Surjit Jutla M.D.

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 09 1997	Julia Davidson-Randall

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17037

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: DELLA MAE BOWMAN
2. Date of Death Month: MAY Day: 27 Year: 97
3. Time of Death: 605 AM
4e. Facility Name *(If not institution, give street and number)*: NORTH CHARLES HEALTHCARE CENTER
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-28-3693
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 99 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 16, 1898
9. Birthplace *(State or Foreign Country)*: Kentucky

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 2700 North Charles Street
10f. Zip Code: 21218
10g. Citizen of What Country?: USA
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 yrs. — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Practical Nurse
16b. Kind of Business/Industry: Health Care
17. Father's Name *(First, Middle, Last)*: Jeb Kendrick
18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Ann Bowling
19e. Informant's Name/Relationship *(Type, Print)*: Ann Moricle (Niece)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 706 S. Grundy Street, Baltimore, MD 21224
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Moreland Mem. Pk. — Date: 5/29/97
20c. Location - City or Town, State: Baltimore, Maryland
21. Signature of Funeral Service Licensee: George J. Fenaux
22. Name and Address of Facility: Mitchell-Wiedefeld Home, 6500 York Road, Baltimore, MD 21212

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. CARDIAC ARREST — IMMEDIATE

Due to (or as a consequence of):
b. ATHEROSCLEROTIC HEART DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ATRIAL FIBRILLATION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☑ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28e. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Alan Levitt MD
29c. License number: 035085
29d. Date signed *(Month, Day, Year)*: 5/29/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ALAN LEVITT MD KENNEDY HOSPITAL BALTIMORE, MD 21207

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After the certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed *(Month, Day, Year)*: JUN 09 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item12 6-12-97 FilmG748 W.H.Per F/H

Certificate of Death

Reg. No. 97 17038

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: WILLIAM LOUIS BURLEY

2. Date of Death — Month: JUNE Day: 02 Year: 1997

3. Time of Death: 11:25 p.m.

4a. Facility Name *(If not institution, give street end number)*: MANOR CARE - RUXTON

4b. City, Town, or Location of Death: TOWSON

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 215-30-4255

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 62 Yrs.

If Under 1 Yaar — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Dey, Yeer)*: DEC 30 1934

9. Birthplece *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedant

10a. State: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: JESSUP

10d. Insida City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 7510 MONTEVIDEO CT

10f. Zip Code: 20794

10g. Citizen of Whet Country?: USA

11. Maritel Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☒ No
If Yes, Give Year or Detes: 1957 to 1959

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1☐ Yes 2☒ No *Specify:*

14. Rece - American Indlen, Bleck, White, etc.
Specify: BLACK

15. Decadent's Education *(Specify only highest grade completed)*
Elementary/Secondary (0-12): 12
College (1-4or 5+):

16a. Decedent's Usual Occupetion *(Giva kind of work done during most of working life. DO NOT use retired)*: DISPATCHER

16b. Kind of Businass/Industry: B & O RAILROAD

17. Fether's Neme *(First, Middla, Last)*: JOHN BURLEY

18. Mothar's Name *(First, Middla, Maiden Surneme)*: EMMA

19a. Informent's Name/Reletionship *(Type, Print)*: LEONIA G BURLEY/ WIFE

19b. Malling Addrass *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 7510 MONTEVIDEO CT, JESSUP, MD 20794

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Othar *(Specify)*

20b. Piece of Disposition *(Name of cemetery, cramatory or other piece)*: CROWNVILLE VETS CEM

Dete: JUN 9

20c. Location - City or Town, Stete: CROWNSVILLE, MD

21. Signature of Funaral Service Licensee: Herbert E. Nutter

22. Name end Address of Facility: NUTTER FUNERAL HOMES, INC
2501 GWYNNS FALLS PKWY BALTO, MD 21216

Physician /Medical Examiner

23a. Part1. Enter the diseesa, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or haart failura. List only ona causa on aach line.

Approximete Intarvel Between Onset end Death

Immediate Ceusa (Final disease or condition resulting in death)
e. Acute Stroke — 1 Week

Dua to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in deeth) Lest
b.
Dua to (or es e consequance of):
c.
Due to (or es e consequance of):
d.

Pert II. **Other eignificent conditions** contributing to death but not rasulting in the undarlying cause given in Part I.

23b. Did tobecco use contribute to the cause of deeth? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an eutopsy performed? 1☐ Yas 2☒ No

24b. Wara eutopsy findings available prior to complation of causa of deeth? 1☐ Yas 2☐ No

25. Wes casa rafarred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*
Hospital: 1☐ Inpatiant 2☐ ER/Outpetient 3☐ DOA
Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding investigation 6☐ Could not be determined

28a. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28b. Time of Injury: M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Data of Injury *(Month, Day Yeer)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*
1☒ **Certifying Phyeician:** To the best of my knowladge, deeth occurred et tha tima, dete end pleca, end due to the ceuse(s) end menner es stetad.
2☐ **Medical Exeminer:** On the basis of examination and/or investigetion, in my opinion, deeth occurred et tha tima, data and piece, end due to tha causa(s) end mannar stated.

29b. Signature end title of certifier: AH Gilad MD

29c. License number: D-12849

29d. Date signed *(Month, Day, Year)*: 6-7-97

30. Nama and address of person who complated causa of death (Item 23a) (Typa, Print): AH. GILADI, M.D. 7680 OSLER Dr. TOWSON, MD 21204

State Registrar

31. Date filed *(Month, Day, Year)*: JUN 09 1997

32. Registrar's Signature

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural," items 28a-f or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17039

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Rowland Andrew Brengle

2. Date of Death: Month May Day 25, Year 1997

3. Time of Death: 9:00 AM

4a. Facility Name (If not institution, give street and number): 326 Cresswell Road

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Anne Arrundel

Funeral Director

5. Social Security Number: 218-03-3987

6. Sex: 1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 26, 1912

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arrundel

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 326 Cresswell Road

10f. Zip Code: 21225

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Salesman

16b. Kind of Business/Industry: Baking Company

17. Father's Name (First, Middle, Last): Harry George Brengle

18. Mother's Name (First, Middle, Maiden Surname): Mamie Louise Applegate

19a. Informant's Name/Relationship (Type, Print): Mildred Brengle/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 326 Cresswell Road, Baltimore, Maryland 21225

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Congestive Heart Failure — 3yrs

Due to (or as a consequence of):

b. Coronary Artery Disease — 5 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Diabetes Millitus — 15 yrs

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Benjamin Berdann

29c. License number: D00751

29d. Date signed (Month, Day, Year): May 29 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): BENJAMIN BERDANN 606 HAMMONDS LANE BALTO MD 21225

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): JUN 09 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17040

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOANN BORSUKIEWICZ
2. Date of Death (Month, Day, Year): MAY. 23. 1997
3. Time of Death: 11:45 P.M.
4a. Facility Name (If not institution, give street and number): Church Home Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 215 28 7607
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 64 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 28, 1932
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore City
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 100 North Broadway
10f. Zip Code: 21231
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? unknown — 1☐ Yes 2☐ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 3 — College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bar Attendant
16b. Kind of Business/Industry: Restaurant

17. Father's Name (First, Middle, Last): John Hilton
18. Mother's Name (First, Middle, Maiden Surname): Mary Korgoka

19a. Informant's Name/Relationship (Type, Print): Regina J. Angelo/sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 720 S. Ponca Street, Baltimore, Maryland 21224

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place)
Date
20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. METASTATIC CANCER OF LUNG — YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: CHRONIC OBSTRUCTIVE PULMONARY - DISEASE.

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ A. P. Nazzeman MD
29c. License number: D17322
29d. Date signed (Month, Day, Year): MAY. 23. 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): A. P. NAZZEMAN MD CHURCH HOSPITAL, BALT MD.

State Registrar

31. Date filed (Month, Day, Year): JUN 09 1997 — Signature

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

97 17041

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 ... the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, ... be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Betty Burton			2. DATE OF DEATH (Month, Day, Year): 05/26/1997	3. TIME OF DEATH: 1:40 AM
4. SOCIAL SECURITY NUMBER: 233-38-2082	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 68 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): October 17, 1928	8. BIRTHPLACE (State or Foreign Country): unknown
9a. FACILITY NAME (If not institution, give street and number): Canton Harbor Healthcare 1300 S. Ellwood Ave.		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore	9c. COUNTY OF DEATH: —	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: —	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1300 S. Ellwood Ave Baltimore, MD		10f. ZIP CODE: 21224	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: unknown	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12	College (1-4 or 5+): ✓	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Waitress	16b. KIND OF BUSINESS/INDUSTRY: unknown

17. FATHER'S NAME (First, Middle, Last): unknown	18. MOTHER'S NAME (First, Middle, Maiden Surname): unknown
19a. INFORMANT'S NAME (Type/Print): unknown	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): unknown

20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify): in state	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ronald S. Wade, Director	22. NAME AND ADDRESS OF FACILITY: State Anatomy Board, 655 W. Baltimore St. Baltimore, Maryland 21201		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Liver Failure	Months
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Liver Cirrhosis	years
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Insulin Dependent Diabetes Mellitus

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. LICENSE NUMBER: D08358	29d. DATE SIGNED (Month, Day, Year): 5/29/97
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): BRACITO Y. PATRICIO	703 S CLINTON ST BALT. MD 21224	
31. DATE FILED (Month, Day, Year): JUN 09 1997	32. REGISTRAR'S SIGNATURE: [signature]	

DHMH-16 Rev 1/89

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17042

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JAMES H. BEESLEY, III
2. Date of Death Month: 06 Day: 06 Year: 1997
3. Time of Death: 1009 PM
4a. Facility Name (If not institution, give street and number): GREATER BALTIMORE MEDICAL CENTER
4b. City, Town, or Location of Death: TOWSON
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 142-16-2814
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JUNE 1 1923
9. Birthplace (State or Foreign Country): CONNECTICUT

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: BALTIMORE
10c. City, Town or Location: TOWSON
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 2 ACORN CIRCLE APT. #201
10f. Zip Code: 21286
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th GRADE | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SUPERVISOR
16b. Kind of Business/Industry: MANFACTURING INDUSTRY

17. Father's Name (First, Middle, Last): JAMES H. BESSLEY, JR.
18. Mother's Name (First, Middle, Maiden Surname): ALICE DOODY

19a. Informant's Name/Relationship (Type, Print): MARY E. BEESLEY WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2 ACORN CIRCLE APT. 201 TOWSON, MD 21286

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): METRO CREMATORY, INC.
Date: 6/9/97
20c. Location - City or Town, State: CATONSVILLE, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD. TOWSON, MD 21286

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

20a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ACUTE LIVER FAILURE — 4 DAYS

Due to (or as a consequence of):
b. ASCVD

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D 23319
29d. Date signed (Month, Day, Year): 6 JUNE 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): N. ROSENBLUM, MD 7600 OSLER DR TOWSON MD 21204

State Registrar

31. Date filed (Month, Day, Year): JUN 09 1997
32. Registrar's Signature: [signature]

To be Completed by Funeral Director

Baltimore, Maryland 21215-0226

permit. Pages 1 and 2 should be filed with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17043

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month / Day / Year	3. Time of Death
Florence	Coster	June 5 1997	9:50 pm

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Stella Maris Hospice	Towson	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-07-4474-D	1☐ M 2☒ F	99 Yrs.			November 15,1897	Pennsylvania

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Baltimore	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6304 Pinehurst Rd.	21212	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yas, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Homemaker	Own home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Harry Ludwig	Mary Hagenbauch

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
J. Benjamin Coster, Jr./son	607 Marwood Rd. Towson, MD 21204

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Bethlehem Memorial Park	6/9/97	Bethlehem, Pennsylvania

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
John O. Mitchell IV	Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, MD 21212

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death: days

Immediate Cause (Final disease or condition resulting in death)
e. Congestive Heart Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	D 15504	6 6 97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Eddie Nakhuda, M.D. 2300 Dulaney Valley Rd, Timonium, Md. 21093

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 0 9 1997	Julia Davidson-Randall

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and copy(ies) filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

97 17044

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ROBERT E. CEASE		2. DATE OF DEATH (Month, Day, Year): May. 29, 1997	3. TIME OF DEATH: 1:45 AM
4. SOCIAL SECURITY NUMBER: 230-34-3289	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 63 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Jan. 3, 1934
8. BIRTHPLACE (State or Foreign Country): Virginia			
9a. FACILITY NAME (If not institution, give street and number): Church Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore	9c. COUNTY OF DEATH: Baltimore City	

RESIDENCE OF DECEDENT

10a. STATE: unknown	10b. COUNTY: unknown	10c. CITY, TOWN OR LOCATION: unknown	10d. INSIDE CITY LIMITS: unk. 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: unknown	10f. ZIP CODE: unknown	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES: unknown	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): unknown; College (1-4 or 5+): unknown	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): unknown	16b. KIND OF BUSINESS/INDUSTRY: unknown	
17. FATHER'S NAME (First, Middle, Last): unknown	18. MOTHER'S NAME (First, Middle, Maiden Surname): unknown		
19a. INFORMANT'S NAME (Type/Print): unknown	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): unknown		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify): in state	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ronald S. Wade, Director	22. NAME AND ADDRESS OF FACILITY: State Anatomy Board, 655 W. Baltimore St. Baltimore, Marylnd 21201		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. PNEUMONIA — DAYS

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC VASCULAR ACCIDENT

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
A.A. Nazemi MD	D17322	▶ May. 29 1997

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): A.A. NAZEMI, M.D. CHURCH HOSPITAL BALT. MD

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE

DHMH-16 Rev 1/89

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17045

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: THOMAS C. CANNON, SR.

2. Date of Death Month Day Year: JUNE 6, 1997

3. Time of Death: 7:30 AM

4a. Facility Name *(If not institution, give street and number)*: 5165 Phantom Court

4b. City, Town, or Location of Death: Columbia

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 460-16-7833

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sept. 10, 1913

9. Birthplace *(State or Foreign Country)*: Texas

Usual Residence of Decedent

10a. State: MD

10b. County: Howard

10c. City, Town or Location: Columbia

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 5165 Phantom Court

10f. Zip Code: 21044

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+): 4+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Teacher

16b. Kind of Business/Industry: Special Education

17. Father's Name *(First, Middle, Last)*: Sidney Cannon

18. Mother's Name *(First, Middle, Maiden Surname)*: Johnetta Watts

19a. Informant's Name/Relationship *(Type, Print)*: Jerry Ann Hunter (Daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5165 Phantom Court, Columbia, MD 21044

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: PARADISE CEMETERY | Date: 06-11-97

20c. Location - City or Town, State: HOUSTON, TEXAS

21. Signature of Funeral Service Licensee: Robert Gregory Burton

22. Name and Address of Facility: Witzke Funeral Homes, Inc. 5555 Twin Knolls Rd. Columbia, MD 21045

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Ischemic cardiomyopathy — 3 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. coronary artery disease

Due to (or as a consequence of):

c. Diabetes

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Lynn D. Alonso M.D.

29c. License number: D32482

29d. Date signed *(Month, Day, Year)*: JUNE 6, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LYNN D. ALONSO, M.D. 8325-E GUILFORD RD., COLUMBIA, MD 21046

State Registrar

31. Date filed *(Month, Day, Year)*: JUN 09 1997

32. Registrar's Signature: Julia Davidson-Rampone

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours of death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural," or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

97-3095-005
CIP
WILLIAM H. CORNELL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17046

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: WILLIAM H. CORNELL, JR.
2. Data of Death Month Day Year: JUNE 7, 1997
3. Time of Death: 9:55AM
4a. Facility Name *(If not institution, give street and number)*: 1601 KNECHT AVENUE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 221-36-1496
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 48 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: 04/23/49
9. Birthplace *(State or Foreign Country)*: DELAWARE

Usual Residence of Decedent

10a. State: DELAWARE
10b. County: NEW CASTLE
10c. City, Town or Location: NEWARK
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: #2 KAYAK COURT
10f. Zip Code: 19702
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): — College (1-4or 5+): 7 YEARS
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: TRUCK DRIVER
16b. Kind of Business/Industry: UNITED ELECTRIC CO.

17. Father's Name *(First, Middle, Last)*: WILLIAM H. CORNELL, SR.
18. Mother's Name *(First, Middle, Maiden Surname)*: EVELYN BARNES

19a. Informant's Name/Relationship *(Type, Print)*: CHRISTINE CORNELL SISTER
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: #2 KAYAK COURT NEWARK, DELAWARE 19702

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: FERNWOOD CEMETERY — Date: 6/11/97
20c. Location - City or Town, State: UPPER DARBY TOWNSHIP DELAWARE COUNTY

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD. TOWSON, MD 21286

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed with the [illegible] death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", "Accident" or "Homicide", items 23a or 28a-f should be completed. In any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Atherosclerotic cardiovascular disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* BUSINESS

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Data of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

29e. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] DIXON
29c. License number: O.C.M.E.
29d. Date signed *(Month, Day, Year)*: JUNE 7, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JUN 09 1997
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17047

Physician /Medical Examiner

1. Decedent's Nema *(First, Middle, Last)*: Frank F. DiLeonardi
2. Dete of Deeth — Month: 5 Day: 22 Year: 1997
3. Time of Deeth: 5:00A
4e. Facility Name *(If not institution, give street end number)*: 3323 Shannon Drive
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Sociel Security Number: 216-20-6459
6. Sex: 1 M 2 F
7. Aga *(In yrs. last birthday)*: 69 Yrs. — If Under 1 Yaer: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Year)*: Jan 21 1928
9. Birthplece *(Stete or Foreign Country)*: Maryland

Usual Residence of Decedant

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 Yes 2 No
10e. Street end Number: 3323 Shannon Drive
10f. Zip Code: 21213
10g. Citizen of Whet Country?: USA

11. Marital Status: 1 Never Married 2 Married 3 Widowed 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No — If Yes, Give Year or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1 Yes 2 No *Specify:*
14. Rece - Americen Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)* — Elemantery/Secondery (0-12): 3rd — College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Assembly Line Man
16b. Kind of Business/Industry: Car Manufacturer

17. Fethar's Name *(First, Middle, Last)*: Vito Dileonardi
18. Mother's Name *(First, Middle, Maiden Surname)*: Gicomina Dileonardi

19e. Informant's Neme/Relationship *(Type, Print)*: Frank J. Dileonardi (Son)
19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 3323 Shannon Drive, Baltimore, Maryland 21213

20a. Mathod of Disposition: 1 Burial 2 Cremation 3 Removal from State 4 Donetion 5 Othar *(Spacify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or othar piece)*: New Cathedral
Dete: 5/27/97
20c. Location - City or Town, Stete: Baltimore, Maryland

21. Signature of Funeral Service Licensee
22. Name end Address of Facility: Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Maryland 21213

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or raspiratory arrast, shock, or heart failure. List only one cause on eech lina.

Approximete Intervel Between Onset end Daath

Immediata Cause (Final diseesa or condition resulting in daath)
a. COPD due to Chronic obstructive pulmonary disease — 4yrs
Due to (or es a consaquance of):
b.
Due to (or es a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in daath) Last

Part II. **Other eignificant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to tha cauae of death?** 1 Yes 2 No 3 Probably 4 Unknown

24e. Wes en eutopsy performed? 1 Yes 2 No
24b. Were eutopsy findings eveileble prior to completion of ceusa of daath? 1 Yes 2 No

25. Wes case referrad to medical examiner? 1 Yes 2 No

26. Place of Deeth *(Check only one)*
Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA
Other: 4 Nursing Home 5 Residance 6 Othar *(Specify)*

27. Menner of Death: 1 Naturel 2 Accident 3 Suicide 4 Homicida 5 Panding investigation 6 Could not be determined

28e. Deta of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1 Yes 2 No
28d. Describe how injury occurred
28a. Place of injury - At home, ferm, street, fectory, offica building, etc. *(Specify)*
28f. Location *(Straet end Number or Rural Route Numbar, City or Town, State)*

29a. Certifier *(Check only one)*
1 **Certifying Physician:** To the best of my knowledge, deeth occurred et tha time, date end plece, and dua to tha causa(s) end menner es steted.
2 **Medical Examiner:** On the basis of exemination end/or investigation, in my opinion, daath occurred et the time, data end place, and due to the ceuse(s) and mannar stated.

29b. Signature end title of certifier: Alan Kimmel MD
29c. License number: D25783
29d. Date signed *(Month, Day, Year)*: 5/22/97

30. Name and address of parson who completed cause of deeth (Item 23e) (Type, Print): Alan Kimmel, MD 220 W. Cold Spring Ln. Balt. MD 21210

State Registrar

31. Dete filed *(Month, Day, Year)*: JUN 09 1997
32. Registrar's Signature: Judy Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or if the decedent died from any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that tha death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

97-2946-510
jhm
ANTONIO
DESHIELDS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items:23a part I,27 per MEO G-748 6/11/97 dh

Certificate of Death

Reg. No. 97 17048

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Antonio F. DeShields
2. Data of Death Month Day Year: MAY 30, 1997
3. Time of Death: 04:10 AM
4a. Facility Name (If not institution, give street and number): 3503 OLD YORK ROAD
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: NA

Funeral Director

5. Social Security Number: 218-86-5694
6. Sex: 1☑ M 2☐ F
7. Age (In yrs. last birthday): 25 Yrs.
If Under 1 Yaar: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Dey, Year): 5-20-72
9. Birthplace (Stete or Foreign Country): MD

Usual Residence of Decedent

10a. Stete: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☑ Yas 2☐ No
10e. Street and Number: 3503 Old York Rd
10f. Zip Code: 21218
10g. Citizen of Whet Country?: USA

11. Marital Status: 1☑ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Detes:
13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yas 2☑ No Specify:
14. Rece - Americen Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondary (0-12): 8th grade; College (1-4or 5+): NA
16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Custodian
16b. Kind of Business/Industry: College

17. Fether's Neme (First, Middle, Last): Sylvester Crudup
18. Mother's Name (First, Middle, Meiden Sumame): Joanne De Shields

19e. Informant's Name/Retationship (Type, Print): Joanne Brooks
19b. Maiting Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 3503 Old York Rd, Balto., MD 2128

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Ramoval from State 4☐ Donation 5☐ Other (Specify)
20b. Piece of Disposition (Name of cemetery, crematory or other piece): Voshell Mem Garden
Date: 6-6-97
20c. Location - City or Town, State: Dundalk, MD

21. Signature of Funeral Service Licensee: Lynette K. Jones
22. Name and Address of Facility: March F. H. East 1101 E. North Ave

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disaasa, or complications that causad tha daath. Do not enter tha mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line.

Approximeta Interval Between Onset and Death

Immediate Cause (Final disaasa or condition resulting in deeth): e. NARCOTISM
Due to (or es e consequence of):
Sequentially list conditions, if any, leading to immediete ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or es a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other signiffcent conditions** contributing to death but not resulting in the underlying cause given in Part t.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24e. Was en eutopsy performed? 1☒ Yes 2☐ No
24b. Wara autopsy findings available prior to completion of causa of death? 1☒ Yas 2☐ No

25. Was cese referred to medicel examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)
27. Menner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☒ Pending investigation 6☐ Could not be determined
28e. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and piece, end due to the ceuse(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end menner steted.
29b. Signature and title of certifier: A. MD IXON
29c. License number: OCME
29d. Data signed (Month, Dey, Yeer): MAY 30, 1997
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JUN 0 9 1997
32. Registrar's Signature: Julia Davidson-Randelle

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after delivery in the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or "with any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17049

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Charlotte A. Danaher
2. Data of Death Month: June Day: 5 Year: 1997
3. Time of Death: 4:30PM
4a. Facility Name *(If not institution, giva street and number)*: Stella Maris Hospice
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-48-7882
6. Sax: 1☐ M 2☒ F
7. Aga *(In yrs. last birthday)*: 90 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Day, Yaar)*: Sept. 12 1906
9. Birthplace *(Stete or Foreign Country)*: Maryland

Usual Residence of Decedent

10e. Stete: Md.
10b. County: Harford
10c. City, Town or Location: Joppa
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 308 Avedon Ct.
10f. Zip Code: 21085
10g. Citizan of What Country?: USA

11. Merital Status: 1☐ Never Merried 2☐ Merried 3☒ Widowed 4☐ Divorcad
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Give Yaar or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, Whita, atc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 | College (1-4or 5+):
16e. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Fether's Neme *(First, Middle, Last)*: Charles Zinkand
18. Mother's Neme *(First, Middle, Meiden Surneme)*: Caroline Graff

19e. Informent's Neme/Reletionship *(Type, Print)*: June M. Danaher/Daughter
19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 308 Avedon Ct. Joppa,Md. 21085

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Dulaney Valley Cemetery
Dete: 6/9/97
20c. Location - Clty or Town, Stete: Timonium,Md.

21. Signature of Funeral Service Licensee: Earl L. Ruck
22. Name end Address of Facility: Ruck Towson Funeral HOme, Inc. 1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

23a. Pert1. Enter the diseases or complicetions that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one ceuse on eech line. — Approximete Interval Between Onset end Death

Immediete Ceuse (Finel diseese or condition resulting in deeth): e. LUNG CA. & METS
Due to (or es e consequence of):
Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Disaasa or Injury thet Initieted events resulting in death) Last:
b. Due to (or es e consequence of):
c. Dua to (or as a consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings availeble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Deeth *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* HOSPICE

27. Menner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28e. Dete of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Descrlbe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end manner es steted. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end piece, and due to the ceuse(s) and mannar stated.

29b. Signeture end title of certifier
29c. License number: D33215
29d. Dete signed *(Month, Day, Year)*: 06/06/97

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Shirley Thompson-Richards,Md. 100 West Rd. #111 Towson,Md. 21204

State Registrar

31. Data filed *(Month, Day, Year)*: JUN 09 1997
32. Registrer's Signetura: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-6020

permit. Pages 1 and 2 should be filed with the funeral director with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than natural, or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17050

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Norleen Geneva Edwards

2. Date of Death: Month June Day 01 Year 97

3. Time of Death: 18:02

4a. Facility Name (If not institution, give street and number): Johns Hopkins Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: NA

Funeral Director

5. Social Security Number: 212-60-8455

6. Sex: 1☐ M 2☐ F XX

7. Age (In yrs. last birthday): 43 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 07-08-53

9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: Md.

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 927 Evesham Avenue

10f. Zip Code: 21212

10g. Citizen of What Country? USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th Grade

College (1-4or 5+): 6years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Supervisor

16b. Kind of Business/Industry: Dept. of Social Ser.

17. Father's Name (First, Middle, Last): Willie Roy Edwards

18. Mother's Name (First, Middle, Maiden Surname): Norleen Felton

19a. Informant's Name/Relationship (Type, Print): Mamie Edwards Gregory

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17911 Bukerhill Road Parkton, Md. 21120

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar hill Cemetery

Date: 06-05-97

20c. Location - City or Town, State: Anne Arundel Co,Md.

21. Signature of Funeral Service Licensee: Karen M. Koger

22. Name and Address of Facility: Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	Bradycardia	30 minutes
Due to (or as a consequence of): b.	Septic shock	3 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c.	Pancreatitis	3months
Due to (or as a consequence of): d.		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary artery disease

Renal Failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)

Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Robert C. Morsinger MD

29c. License number: D46382

29d. Date signed (Month, Day, Year): June 2, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert C. Morsinger MD 600 N. Wolfe St. Baltimore, MD 21287

State Registrar

31. Date filed (Month, Day, Year): JUN 09 1997

32. Registrar's Signature: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a through 24b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17051

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Helen Josephine French

2. Date of Death Month: JUNE Day: 1 Year: 1997

3. Time of Death: 12 26 PM

4a. Facility Name (If not institution, give street and number): Union Memorial Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-52-0313

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 46 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 17, 1950

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore City

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 5046 Wright Avenue

10f. Zip Code: 21205

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indien, Black, White, etc. Specify: White

15. Decedent's Eduestion (Specify only highest grede completed): Elementery/Secondary (0-12): 12 Years; College (1-4or 5+):

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Bank Teller

16b. Kind of Business/Industry: Banking

17. Fether's Name (First, Middle, Last): William Kessler

18. Mother's Name (First, Middle, Meiden Surneme): Theresa Kordek

19a. Informent's Neme/Reletionship (Type, Print): Dawn M. French/Daughter

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 4163 Madonna Road Jarrettsville, MD 21084

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Holly Hill Mem. Gdns. Date: 6/4/1997

20c. Location - City or Town, Stete: Middle River, MD

21. Signeture of Funeral Service Licensee: ▶ Johnny L Gibbs

22. Neme end Address of Feciliity: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23e. Part I. Enter the disease, or complicetions thet caused the death. Do not enter the mode of dying, such es cerdiec or respirefory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Death

Immediete Cause (Finel disease or condition resulting in death): e. Shock — 1 hr 30 min

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leeding to immediete ceuse. Enter Underlying Ceuse (Diseese or Injury thet Initieted events resulting in deeth) Last:

b.

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: Metabolic Acidosis, Coronary Disease Renal Failure

23b. Did tobecco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Piece of Deeth (Check only one): Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physicien**: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) end menner es steted. 2☐ **Medical Examiner**: On the basis of exemineticn end/or investigetion, in my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: ▶ A Nathan M.D.

29c. License number: AT2483946

29d. Dete signed (Month, Dey, Year): JUNE 1, 1997

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Aruna S. Nathan M.D. Union Memorial Hospital

State Registrar

31. Dete filed (Month, Dey, Year): JUN 09 1997

32. Registrer's Signeture: Julia Davidson-Ramsdell

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 24 hours of death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "Natural" or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Helen J French

12

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17052

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Emmett M. Ford

2. Date of Death: Month June Day 7, Year 1997

3. Time of Death: 8:21 AM

4a. Facility Name (If not institution, give street and number): VA Maryland Health Care System

4b. City, Town, or Location of Death: Perry Point

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 216 28 8313

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 66 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 26,1931

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Essex

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 59 Marice Circle

10f. Zip Code: 21221

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [XX] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1950

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 7

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Truck Driver

16b. Kind of Business/Industry: Transport Shipping

17. Father's Name (First, Middle, Last): David Albert Ford

18. Mother's Name (First, Middle, Maiden Surname): Alice Margaret Little

19a. Informant's Name/Relationship (Type, Print): Velvet G. Kitzmiller / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 45 Luke Dr., Pasadena, MD 21122

20a. Method of Disposition: 1 [ ] Burial 2 [XX] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Green Mount Crematory

Date: 6/9/97

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Stephen D Lohrmann

22. Name and Address of Facility: CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD 21286

Name known to Physician: EMMETT M. FORD

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within [illegible] days after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "Natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complicetions thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in deeth)

a. Chronic renal failure — Unknown

Due to (or as a consequenca of):

b. Diabetes mellitus, non-insulin dependent — Unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that tnitiated events resulting in death) Lest

Due to (or as a consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residenca 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature end title of certifier: Arastoo Yazdani MD

29c. License number: D50454

29d. Date signed (Month, Dey, Yeer): June 7, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Arastoo Yazdani, M.D., VA Maryland Health Care System, Perry Point, MD 21902

State Registrar

31. Date filed (Month, Day, Year): JUN 09 1997

32. Registrar's Signature: Julia Richardson-Randall

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17053

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Hazel E. Gardiner

2. Date of Death: Month June Day 4 Year 1997

3. Time of Death: 2:52 pm

4a. Facility Name *(If not institution, give street and number)*: Maryland General Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: NA

Funeral Director

5. Social Security Number: 217-24-3699

6. Sex: 1☐ M 2☐ F XX

7. Age *(In yrs. last birthday)*: 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 09-07-18

9. Birthplace *(State or Foreign Country)*: MD.

Usual Residence of Decedent

10a. State: Md

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: XX 1☒ Yes 2☐ No

10e. Street and Number: 2006 Division Street

10f. Zip Code: 21217

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8th Grade; College (1-4or 5+): NA

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Laborer

18b. Kind of Business/Industry: Various Trades

17. Father's Name *(First, Middle, Last)*: Joseph Mitchell

18. Mother's Name *(First, Middle, Maiden Surname)*: Henrietta Moaney

19a. Informant's Name/Relationship *(Type, Print)*: Rochelle Maria Roberts

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4843 Aberdeen Avenue Baltimore, Md. 21206

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Voshell Mem. Gardens

Date: 06-07-97

20c. Location - City or Town, State: Dundalk, Md.

21. Signature of Funeral Service Licensee: Karen M. Kozer

22. Name and Address of Facility: Baltimore, Maryland 21202

WM.C. March FH 1101 E. North Avenue

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed with the local registrar of births and deaths within 5 days after death with the Maryland Department of Health and Mental Hygiene, 4201 Patterson Avenue, Baltimore, MD 21215-2399.
Important: If item 27 is marked other than "Natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

b. Arrhythmia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Fibrillation with Rapid Ventricular Rate

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Nkemenkolo Kolongo MD

29c. License number: 89247

29d. Date signed *(Month, Day, Year)*: 6/4/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Nsekinene Kolongo, M.D. c/o Maryland General Hospital.

State Registrar

31. Date filed *(Month, Day, Year)*: JUN 09 1997

32. Registrar's Signature: Gina Davidson-Randall

DHMH 16 Rev 6/95

97-3026-510
AM
ANNA
GARRETT

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17054

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Anna Mary Garrett
2. Date of Death (Month Day Year): JUNE 03, 1997
3. Time of Death: 3:14 P
4a. Facility Name (If not institution, give street and number): 6313 WALTHER AVE.
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-18-0831
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 24, 1920
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 6313 Walther Avenue
10f. Zip Code: 21206
10g. Citizen of Whet Country?: United States

11. Meritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decadent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Edcetion (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Henry Preller
18. Mother's Name (First, Middle, Maiden Surname): Mary Agnes Watson

19e. Informant's Name/Relationship (Type, Print): Mrs.Cheryl L. Gosnell / Friend
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 5120 E. Joppa Road Perry Hall, Maryland 21128

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Most Holy Redeemer Cemetery
Date: 6/7/97
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Mark T. Zavoyna
22. Name and Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214

Physician /Medical Examiner

23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): e. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last

b. Due to (or as a consequenca of):

c. Due to (or es e consequence of):

d.

Part II. **Other alginificant conditiona** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? INSPECTED 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☒ No

25. Was cese referred to medical examiner? ☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end place, end due to the cause(s) end menner es steted. 2☒ **Medicel Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) end manner stated.

29b. Signature end title of certifier
29c. License number: OCME
29d. Date signed (Month, Dey, Yeer): JUNE 04, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David Fowler, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JUN 09 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or if item 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17055

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Lest)*: George Green

2. Dete of Deeth — Month / Day / Yeer: June 1, 1997

3. Tima of Deeth: 12:20 a.m.

4a. Facility Neme *(If not institution, give street and number)*: 720 N. Hilton Street

4b. City, Town, or Location of Deeth: Baltimore

4c. County of Deeth: CITY

Funeral Director

5. Sociel Security Number: 217-07-6878

6. Sex: 1☒M 2☐F

7. Age *(In yrs. lest birthday)*: 87 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Yeer)*: DEC 4,1909

9. Birthplece *(State or Foreign Country)*: NORTH CAROLINA

Usual Residence of Decedent

10e. Stete: MARYLAND

10b. County: CITY

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street end Number: 720 N. HILTON STREET

10f. Zip Code: 21229

10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☐Merried 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Yeer or Dates: 42-45

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐Yes 2☒No *Specify:*

14. Race - American Indien, Black, White, etc. *Specify:* AFRO. AMERICAN

15. Decedent's Education *(Specify only highest grede completed)*: Elemantery/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use ratired)*: LONGSHOREMAN

16b. Kind of Business/Industry: BETHLEHEM STEEL CORP.

17. Father's Neme *(First, Middle, Lest)*: GEORGE GREEN

18. Mother's Nama *(First, Middle, Maiden Surneme)*: IRENE GREEN

19a. Informent's Name/Relationship *(Type, Print)*: JEWELL HALL

19b. Mailing Address *(Street end Numbar or Rural Route Number, City or Town, Stete, Zip Code)*: 720 N. HILTON STREET, BALTIMORE, MARYLAND 21229

20e. Method of Disposition: 1☒Burial 2☐Cremetion 3☐Removal from State 4☐Donetion 5☐Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: GARRISON FOREST CEMETERY — Dete: 6/6/97

20c. Location - City or Town, Stete: OWINGS MILL, MD.

21. Signeture of Funeral Service Licensee: Floyd M. Estep

22. Name and Address of Facility: ESTEP BROTHERS FUNERAL HOME, P.A. 1300 EUTAW PLACE, BALTIMORE, MARYLAND 21217

Physician /Medical Examiner

23a. Part I. Enter the diseasa, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one ceuse on eech line. — Approximete Interval Between Onsat end Death

Immediete Causa (Finel disease or condition resulting in death)

a. Myocardial Infarction

Dua to (or as a consequence of):

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceusa (Diseese or injury thet initiated events resulting in deeth) Last

b. Atherosclerotic Cardiovascular Disease

Due to (or as e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. **Did tobacco use contribute to the cause of death?** 1☐**Yes** 2☐**No** 3☒**Probably** 4☐**Unknown**

24a. Wes en eutopsy performed? 1☐Yes 2☒No

24b. Ware eutopsy findings eveileble prior to completion of cause of daeth? 1☐Yes 2☐No

25. Wes casa referred to medical examiner? 1☐Yes 2☒No

26. Plece of Daath *(Check only ona)* — Hospitel: 1☐Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☐Nursing Home 5☒Residenca 6☐Other *(Specify)*

27. Mennar of Deeth: 1☒Naturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28e. Deta of Injury *(Month, Dey Year)*

28b. Time of Injury

28c. Injury et Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, offica building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, deeth occurred et the tima, data and piece, end due to tha cause(s) end menner es statad. 2☐**Medical Examiner:** On the basis of exeminetion end/or investigetion, in my opinion, daath occurred et the time, date end placa, and due to tha cause(s) end menner steted.

29b. Signeture end title of certifier: Mohamed Al-Ibrahim

29c. License number: D15450

29d. Dete signed *(Month, Dey, Yeer)*: 6/4/97

30. Nama end eddress of person who completed cause of deeth (Item 23a) (Type, Print): Mohamed Al-Ibrahim, M.D., 10 N. Greene Street, Baltimore, MD 21201

State Registrar

31. Dete filed *(Month, Day, Yeer)*: JUN 09 1997

32. Registrer's Signature: Gina Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be [illegible] hours after death with the Maryland Department of Health and Mental [illegible]. **Important:** If item 27 is marked [illegible], or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Item17 6-9-97 FilmG748 W.H.Per F/H

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17056

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): EDGAR HARRIS JR

2. Dete of Deeth: Month JUNE Dey 6 Yeer 1997

3. Time of Death: 0535

4a. Facility Neme (If not institution, give street end number): Sinai Hospital of Baltimore

4b. City, Town, or Location of Death: Baltimore

4c. County of Deeth: NA

Funeral Director

5. Socie! Security Number: 230-52-4060

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 56 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Yeer): DEC. 24, 1940

9. Birthplace (Stete or Foreign Country): VA

Usual Residence of Decedent

10a. Stete: Md

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street end Number: 2615 Woodland Ave

10f. Zip Code: 21215

10g. Citizen of Whet Country?: USA

11. Marital Status: 1 ☐ Never Merried 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Rece - American Indian, Bleck, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondery (0-12): 12th | College (1-4or 5+): NA

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): MECHANIC

16b. Kind of Business/Industry: MASS TRANSIT Admn.

17. Fether's Neme (First, Middle, Last): Edgar ~~EDGAR~~ Harris Sr.

18. Mother's Neme (First, Middle, Meiden Surneme): Cora Harris

19a. Informent's Neme/Reletionship (Type, Print): Mary J. HARRIS - Wife

19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 2615 Woodland Ave. Balto. Md. 21215

20a. Methed of Disposition: 1 ☒ Buriel 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Arbutus Memorial Park | Dete: 6.10.97

20c. Location - City or Town, State: Arbutus, Md

21. Signeture of Funerel Servica Licensee: Glynna B. Harris

22. Neme end Address of Feciity: March Funeral Home-West 4300 Wabash Ave. Balto md. 21215

Physician /Medical Examiner

23a. Pert I. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert feilure. List only one ceuse on eech line.

Approximete interval Between Onset and Death

Immediate Ceuse (Finel disease or condition resulting in deeth)

e. Hemorrhagic stroke

Due to (or es e consequence of):

Sequentielly list conditions, if any, leading to immediete cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest

b. Left Lower Lung pneumonia

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Pert Ii. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Pert I.

Atrial fibrillation with rapid ventricular response

23b. Did tobacco use contribute to the cauee of death? 1 ☐ Yee 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Wes en eutopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1 ☐ Yes 2 ☒ No

25. Wes case referred to medical exeminer? 1 ☐ Yes 2 ☒ No

26. Piece of Deeth (Check only one): Hospitel: 1 ☒ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Menner of Deeth: 1 ☒ Neturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end piece, and due to the ceuse(s) end menner es steted. 2 ☐ **Medical Examiner:** On the besis of exemlnetion end/or Investigetion, in my opinion, deeth occurred et the time, date end piece, and due to the ceuse(s) end manner steted.

29b. Signeture end title of certifier:

29c. License number: AS 2402321-ST-9027

29d. Date signed (Month, Day, Year): June 6, 1997

30. Neme end address of person who completed cause of deeth (Item 23a) (Type, Print): SEAN H. TRETIAK

State Registrar

31. Dete filed (Month, Dey, Yeer): JUN 09 1997

32. Registrer's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", "accident" or "suicide" or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17057

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Thomas H. Humber

2. Dete of Deeth: Month June, Dey 6, Yeer 1997

3. Time of Death: 12:45am

4a. Feclity Neme *(If not Institution, give street end number)*: John Hopkins Bayview Medical Ctr.

4b. City, Town, or Location of Deeth: Baltimore

4c. County of Deeth: n/a

Funeral Director

5. Social Security Number: 215-30-9570

6. Sex: XX M 2☐ F

7. Age *(In yrs. lest birthday)*: 65 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey. Yeer)*: 7/22/31

9. Birthplace *(Stete or Foreign Country)*: Ga

Usuel Residence of Decedent

10a. Stete: MD

10b. County: Baltimore

10c. City, Town or Location: Dundalk

10d. Inside City Limits: 1☐ Yes XX No

10e. Street end Number: 109 Fleming Dr.

10f. Zip Code: 21222

10g. Citizen of Whet Country?: USA

11. Maritel Status: XX Never Married 2☐ Merried 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever In U.S. Armed Forces? 1☐ Yes 2XX No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes XX No *Specify:*

14. Race - American indian, Bleck, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 2

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Truck Driver

16b. Kind of Business/Industry: Mclean

17. Fether's Neme *(First, Middle, Last)*: Charlie Humber

18. Mother's Name *(First, Middle, Maiden Surneme)*: Louisa Willis

19a. Informent's Neme/Reletionship *(Type, Print)*: Vincent Moore/ son

19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 2206 Crossett Rd. Balto., MD 21237

20e. Method of Disposition: XX Buriel 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Plece of Disposition *(Neme of cemetery, cremetory or other piece)*: Garrison Forest VA

Dete: 6/10

20c. Location - City or Town, State: Owings Mills, MD

21. Signeture of Funeral Service Licensee: James A. Morton

22. Neme end Address of Feclity: James A. Morton & Sons Funeral Home 1701 Laurens St. Balto., MD 21217

To Be Completed by Funeral Director

Baltimore, Maryland 21216-0020

permit. Pages 1 end 2 shall be completed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked 'Natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Pert I. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock or heart feilure. List only one cause on each line.

Approximate Interval Between Onset end Deeth

Immediete Ceuse (Finel diseese or condition resulting in death): e. SMALL CELL LUNG CANCER — 6 MONTHS

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leading to immediete cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Lest:

b.

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. **Did tobacco use contribute to the cauee of death?** 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Plece of Death *(Check only one)*: Hospital: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☐ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death.

To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the buriel-transit

Division of Vital Records, P.O. Box 68760,

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledge, death occurred et the time, dete end pleca, end due to the ceuse(s) end menner as steted. 2☐ **Medical Examiner**: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, dete end piece, end due to the cause(s) end menner steted.

29b. Signeture end title of certifier: M. Purtell

29c. License number: 019714

29d. Dete signed *(Month, Dey, Yeer)*: 6/6/97

30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print): MICHAEL PURTELL JHBVMC 4940 EASTERN AVE, BALTIMORE MD

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State Registrar

31. Dete filed *(Month, Dey, Yeer)*: JUN 09 1997

32. Registrar's Signeture

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17058

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Virginia R. Hooten
2. Date of Death: Month 6 Day 6 Year 97
3. Time of Death: 0055
4a. Facility Name (If not institution, give street and number): University of Maryland Medical Systems
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: 234-46-0642
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 67 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 09/29/1929
9. Birthplace (State or Foreign Country): VA.

Usual Residence of Decedent

10a. State: MD.
10b. County: Queen Anne's
10c. City, Town or Location: Stevensville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 101 Big Holly Court
10f. Zip Code: 21666
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Walter M. Gaylor
18. Mother's Name (First, Middle, Maiden Surname): Hattie Burke

19a. Informant's Name/Relationship (Type, Print): Thomas H. Hooten (Husband)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 101 Big Holly Ct. Stevensville, MD. 21666

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley
Date: 6/10/97
20c. Location - City or Town, State: Timonium, MD.

21. Signature of Funeral Service Licensee: Dawn C. Canall
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD. 21204

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Pulmonary Hemorrhage — 1 hour

Due to (or as a consequence of):
b. Chronic Obstructive Lung Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

26a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: A Reiss MD
29c. License number: P09755
29d. Date signed (Month, Day, Year): 06/06/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Alex Reiss MD 20 S. Greene St Baltimore MD 21201

State Registrar

31. Date filed (Month, Day, Year): JUN 09 1997
32. Registrar's Signature:

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours of death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or if items 26a or 26a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17059

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Robert Wesley Hairsine

2. Dete of Deeth Month Dey Yaar: June 6, 1997

3. Time of Deeth: 3:45 AM

4e. Facility Name (If not institution, giva street and number): 7816 St. Clair Lane

4b. City, Town, or Location of Deeth: Dundalk

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-24-3923

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. lest birthday): 67 Yrs.

If Under 1 Yaar: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Day, Year): July 29, 1929

9. Birthpleca (State or Foreign Country): Maryland

Usuel Residence of Decedent

10e. Stete: Maryland

10b. County: Baltimore

10c. City, Town or Location: Dundalk

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 7816 St. Clair Lane

10f. Zip Code: 21222

10g. Citizen of What Country?: United States

11. Maritel Stetus: 1☐ Never Merried 2☒ Merried 3☐ Widowed 4☐ Divorced

12. Was Dacedent Ever in U.S. Armed Forces? 1☒ Yas 2☐ No If Yes, Give Year or Detes:

13. Was Dacedent of Hispenic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Rece - Amarican Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grada completed): Elementery/Secondery (0-12): 12 Years; College (1-4or 5+):

16e. Dacedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Police Officer

16b. Kind of Business/Industry: Law Enforcement

17. Fether's Neme (First, Middle, Last): Robert Hairsine

18. Mother's Name (First, Middla, Maiden Sumeme): Nellie Phipps

19e. Informant's Name/Relationship (Type, Print): Wife Mrs. Delores E. Hairsine

19b. Mailing Address (Streat end Numbar or Rural Routa Number, City or Town, Stete, Zip Coda): 7816 St. Clair Lane Dundalk, Maryland 21222

20e. Method of Disposition: 1☐ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☒ Other (Specify) Entombment

20b. Piece of Disposition (Nema of cemetery, cremetory or othar piece): Holly Hill Mem. Gdns.

Date: 6/8/1997

20c. Location - City or Town, Stete: Middle River, MD

21. Signature of Funerel Service Licansee: Chas W. Fisher

22. Neme and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Pert1. Enter tha diseese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

Approximata Interval Between Onsat and Death

Immediate Ceusa (Final disease or condition resulting in death): e. Metastatic lung cancer — 6 months

Dua to (or es a consequence of):

Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Ceuse (Diseese or Injury thet initieted avants resulting in death) Lest:

b. Dua to (or es e consequence of):

c. Due to (or es e consequenca of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings eveileble prior to completion of causa of daath? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yas 2☒ No

26. Piece of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Othar (Specify)

27. Manner of Deeth: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding Investigation 6☐ Could not be determined

28e. Date of Injury (Month, Dey Year):

28b. Time of Injury M:

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Dascribe how injury occurred

28a. Placa of Injury - At homa, farm, straat, factory, office building, etc. (Specify):

28f. Location (Street end Number or Rural Route Number, City or Town, Stete):

29a. Cartifier (Check only one): 1☒ **Certifying Physician:** To tha best of my knowledga, daath occurred at tha time, dete end pleca, end due to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On the besis of axamination end/or investigation, in my opinion, daath occurred at tha tima, date and placa, end due to the cause(s) end manner steted.

29b. Signeture and title of certifier: M. Purtell

29c. Licansa number: D19714

29d. Dete signed (Month, Dey, Yeer): 6/6/97

30. Neme end eddrass of person who completed cause of deeth (Item 23a) (Type, Print): MICHAEL PURTELL JHBMC 4940 EASTERN AVE, BALTIMORE MD 21224

State Registrar

31. Deta filed (Month, Day, Year): JUN 0 9 1997

32. Registrer's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours of pronouncing death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural," or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17060

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Lois Heintzelman

2. Deta of Deeth — Month: June Day: 6 Yaar: 1997

3. Time of Deeth: 11:17PM

4e. Facility Name (If not institution, give street end number): Good Samaritan Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: City

Funeral Director

5. Social Security Number: 212-26-7127

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthdey): 68 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Year): September 1,1928

9. Birthplece (State or Foraign Country): Maryland

Usual Residence of Decedent

10e. Stete: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yas 2☐ No

10e. Street end Number: 1256 Cedarcroft Road

10f. Zip Code: 21239

10g. Citizen of Whet Country?: United States

11. Marital Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Datas:

13. Was Decadent of Hispenic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.): 1☐ Yes 2☒ No Specify:

14. Reca - American Indien, Bleck, Whita, atc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondery (0-12): 7 College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Fether's Neme (First, Middle, Last): Ernest Elmer Myers

18. Mother's Name (First, Middle, Maiden Surneme): Martha Ellen Hamilton

19e. Informent's Neme/Relationship (Type, Print): Mrs. C. Marguerite Reinhold/Aunt

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 6318 Dogwood Road Woodlawn, Maryland 21207

20e. Method of Disposition: 1☒ Buriel 2☐ Cremation 3☐ Removel from State 4☐ Donation 5☐ Othar (Spacify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Pleasant Grove U.M.C. Cemetery

Data: 6/10/97

20c. Locetion - City or Town, Stete: Reisterstown, Maryland

21. Signetura of Funeral Servica Licansee: Brian A. Willem ▶ Brian A. Willem

22. Nama end Address of Facility: Leonard J. Ruck Funeral Home, Inc. 5305 Harford Road Baltimore, Maryland 21214

Physician /Medical Examiner

23e. Part1. Entar the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heert feilure. List only one ceuse on eech line.

Approximeta Interval Between Onset and Death

Immediete Ceuse (Finel diseese or condition resulting in deeth)

e. Cardiogenic Shock — 1 hour

Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury thet Initieted events resulting in deeth) Last

b. Myocardial Ischemia

Due to (or es e consequenca of):

c. Coronary Artery Disease

Due to (or es e consequenca of):

d.

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes en eutopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings eveileble prior to completion of cause of death? 1☐ Yas 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Plece of Deeth (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending invastigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒ **Certifying Physicien:** To the best of my knowledge, death occurred et the time, dete end place, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the besis of examinetion and/or investigation, in my opinion, deeth occurred et the time, dete end piece, and due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: ▶ Edward Allen Seidel

29c. License number: D24918

29d. Date signed (Month, Dey, Year): June 6, 1997

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Edward Allen Seidel MD, 5601 Loch Raven, Baltimore MD 21239

State Registrar

31. Dete filed (Month, Day, Year): JUN 09 1997

32. Registrer's Signature: Gina Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be presented to the registrar within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked Other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17061

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elaine Hedges
2. Date of Death (Month, Day, Year): June 5 1997
3. Time of Death: 0930 Am
4a. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: n/a

Funeral Director

5. Social Security Number: 126 22 5099
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 18, 1927
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 317 Hawthorn Rd.
10f. Zip Code: 21210
10g. Citizan of Whet Country?: United States

11. Maritel Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Yaar or Dates:
13. Was Dacedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - Americen Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 | College (1-4or 5+): 5+
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher / Scholar
16b. Kind of Business/Industry: Education / University

17. Father's Neme (First, Middle, Last): John Ryan
18. Mother's Name (First, Middle, Maiden Surname): Cathryn Ryan

19a. Informant's Neme/Relationship (Type, Print): William L. Hedges / Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 317 Hawthorn Rd., Baltimore, MD 21210

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Green Mount Crematory
Date: 6/9/97
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Stephen D Lohrmann
22. Name and Address of Facility: CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD 21286

Physician /Medical Examiner

23e. Part1. Enter the diseesa, or complicetions thet caused the death. Do not enter tha moda of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Intervel Between Onset and Deeth
Immediete Ceuse (Final diseese or condition resulting in deeth) a.	Massive Upper G I Bleed	~30hr
Due to (or es e consequence of):	Sepsis	~20hr
Sequantially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in deeth) Lest b.		
Due to (or es e consequence of): c.		
Due to (or es e consaquance of): d.		

Part II. **Other sfgnificant conditione** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☑ Yes 2☐ No

24b. Were eutopsy findings aveileble prior to completion of ceuse of deeth? 1☑ Yes 2☐ No

25. Was case referred to medicel exeminer? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physfcian:** To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) end manner es stated. 2☐ **Medical Exeminer:** On the besis of examination end/or Investigation, in my opinion, deeth occurred et the time, date and piece, and due to the cause(s) end menner stated.

29b. Signatura and title of certifier: Dorothea Dobson MD
29c. License number: AS240232 1DAD9030
29d. Data signad (Month, Day, Year): June 5 1997

30. Neme end address of person who completed ceuse of deeth (Item 23a) (Type, Print): Dorothea Dobson Sinai Hospital of Baltimore

State Registrar

31. Dete filed (Month, Day, Year): JUN 09 1997
32. Registrar's Signature: Julie Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be completed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the daath certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17062

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Bernard Ibex

2. Dete of Deeth: Month 06 Dey 06 Yeer 97

3. Time of Death: 23:24

4a. Fecility Neme *(If not institution, give street and number)*: Sinai Hospital of Baltimore

4b. City, Town, or Location of Deeth: Baltimore

4c. County of Deeth: N/A

Funeral Director

5. Social Security Number: 217-18-6523

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthdey)*: 76 Yrs.

If Under 1 Yeer: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Yeer)*: Feb. 05, 1921

9. Birthplece *(Stete or Foreign Country)*: Baltimore, Md.

Usuel Residence of Decedent

10a. State: Maryland

10b. County: Baltimore Co.

10c. City, Town or Location: Lutherville

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street end Number: 1400 Belmore Court

10f. Zip Code: 21093

10g. Citizen of Whet Country?: United States

11. Maritel Stetus: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: 2/24/45 12/31/45

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1☐Yes 2☒No Specify:

14. Race - Americen Indien, Bleck, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondery (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Firefighter

16b. Kind of Business/Industry: Fire Dept./Balto.City

17. Fether's Neme *(First, Middle, Last)*: Joseph H. Ibex

18. Mother's Neme *(First, Middle, Meiden Surneme)*: Lillian A. Fisher

19a. Informent's Neme/Reletionship *(Type, Print)*: Mrs. Anna R. (nee Mettee) Ibex (Wife)

19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 1400 Belmore Court Lutherville, Maryland 21093

20a. Method of Disposition: 1☒Burial 2☐Cremetion 3☐Removel from State 4☐Donetion 5☐Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Dulaney Valley Mem.Gard.

Dete: 6/10/97

20c. Location - City or Town, Stete: Timonium, Maryland

21. Signeture of Funerel Service Licensee: Jeffrey L. Gair

22. Neme end Address of Fecility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson,Md. 21204

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immediate Ceuse (Finel diseese or condition resulting in death)

a. brainstem herniation — 12 hrs

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet initiated events resulting in deeth) Lest

b. intracerebral hemorrahge — 15 hrs

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of deeth?** 1☐Yes 2☐No 3☐Probably ☒Unknown

24a. Wes en eutopsy performed? 1☐Yes 2☒No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1☐Yes ☒No

25. Was case referred to medical exeminer? 1☐Yes 2☒No

26. Piece of Deeth *(Check only one)*: Hospital: 1☒Inpetient 2☐ER/Outpetient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Menner of Deeth: 1☒Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigetion 6☐Could not be determined

28a. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: ☒1 **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete end piece, end due to the cause(s) end menner es steted.

☐2 **Medical Exeminer:** On the besis of examination end/or investigetion, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) end menner stated.

29b. Signeture end title of certifier: Simon C Means MD

29c. License number: AJ4147357

29d. Dete signed *(Month, Dey, Yeer)*: 6/6/97

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Simon C Means

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: JUN 0 9 1997

32. Registrer's Signeture: Madison-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be completed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than natural, or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17063

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary Jones

2. Date of Death Month / Day / Year: June 8th, 1997

3. Time of Death: 1245 pm

4a. Facility Name *(If not institution, give street and number)*: Johns Hopkins - Bayview

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-38-4373

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 57 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 18, 1940

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Edgemere

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2514 Sycamore Ave.

10f. Zip Code: 21219

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Instructional Aid

16b. Kind of Business/Industry: Balto. Co. Board of ED

17. Father's Name *(First, Middle, Last)*: John Ollie Pope

18. Mother's Name *(First, Middle, Maiden Surname)*: Ola Velle Porter

19a. Informant's Name/Relationship *(Type, Print)*: John H. Jones/husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2514 Sycamore Ave. Balto., MD 21219

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Holly Hills | Date: 6/11

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: James A. Morton

22. Name and Address of Facility: James A. Morton & Sons Funeral Home 1701 Laurens St. Ballto., MD 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Ceuse (Final disease or condition resulting in death) a.	ARDS	
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lest b.	Sepsis	
Due to (or as a consequence of):		
c.	Renal Failure	
Due to (or as a consequence of):		
d.	NON G-ware M.I.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: G.I. Bleed

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)* | 28b. Time of Injury | M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physicien**: To the best of my knowledge, death occurred at the time, date and piece, end due to the ceuse(s) end manner as stated. 2☐ **Medical Examiner**: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Louise McCullough MD, PhD

29c. License number: 96709

29d. Date signed *(Month, Day, Year)*: June 8th, 1997

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print): Louise McCullough, MD & PhD Johns Hopkins Bayview, Baltimore MD.

State Registrar

31. Date filed *(Month, Day, Year)*: JUN 09 1997

32. Registrar's Signature: Julia Wilson-Mandell

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within [illegible] with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "Natural" or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

RKD

97-3057-510

SHIRLEY

JAMES Items:23a part I,27 per MEO G-749 7/1/97 dh

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17064

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Shirley Lee James

2. Dete of Deeth — Month: JUNE Day: 05 Yeer: 1997

3. Time of Deeth: 7:02A.M

4a. Feclity Neme (If not institution, give street end number): JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: NA

Funeral Director

5. Social Security Number: 216-72-9705

6. Sex: 1☐ M 2☑ F

7. Age (In yrs. lest birthday): 27 Yrs.

If Under 1 Yeer: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Yeer): NOV. 14, 1969

9. Birthplece (Stete or Foreign Country): Md

Usuel Residence of Decedent

10a. State: Md

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☑ Yes 2☐ No

10e. Street end Number: 2847 Boarman Ave

10f. Zip Code: 21215

10g. Citizen of Whet Country? USA

11. Meritel Status: 1☑ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:

14. Rece - Americen Indien, Black, White, etc. Specify: Black

15. Decedent's Edeceition (Specify only highest grede completed)

Elementery/Secondary (0-12): 8th

College (1-4or 5+): NA

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Cashier

16b. Kind of Business/Industry: Restaurant

17. Fethar's Name (First, Middle, Last): Cefus James

18. Mother's Name (First, Middle, Maiden Surneme): Sarah Powell

19a. Informent's Neme/Relationship (Type, Print): Sarah James - Mother

19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code): 2847 Boarman Ave. Balto. md. 21215

20a. Method of Disposition: 1☑ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other place): Woodlawn Cemetery

Dete: 6-11-97

20c. Location - City or Town, State: Balto. Md

21. Signeture of Funeral Service Licensee: Glynn B. Harris

22. Neme and Address of Facility: March Funeral Home-West 4300 Wabash Ave. Balto. Md 21215

Physician /Medical Examiner

23e. Part1. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in deeth)

e. CARDIAC ARRHYTHMIA

Due to (or as e consequence of):

Sequentially list conditions, if eny, leading to Immediete ceuse. Enter Underlying Cause (Diseese or injury thet initieted events resulting in deeth) Lest

b. LEFT BUNDLE BRANCH FIBROSIS

Due to (or es e consequence of):

c.

Due to (or as e consequence of):

d.

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. **Did tobecco uee contribute to the cause of deeth?** 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings eveileble prior to completion of ceuse of deeth? 1☒ Yes 2☐ No

25. Wes case referred to medical examiner? 1☒ Yes 2☐ No

26. Plece of Deeth (Check only one)

Hospital: 1☐ Inpetient 2☒ ER/Outpetient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Yeer)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)

1☐ **Certifying Phyeician:** To the best of my knowtedge, deeth occurred at the time, dete end plece, end due to the ceuse(s) and manner as stated.

2☒ **Medical Exeminer:** On the besis of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end manner stated.

29b. Signeture and title of certifier: Lara Locke MD

29c. License number: O.C.M.E.

29d. Dete signed (Month, Day, Yeer): JUNE 5, 1997

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): J. LATON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Day, Yeer): JUN 09 1997

32. Registrer's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed with the registrar of vital statistics where death occurred within 24 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than natural, or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17065

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Viola Virginia Judy
2. Data of Daath: Month June; Day 4; Yaar 1997
3. Tima of Death: 8:55 pm
4a. Facility Nama (If not institution, give street and number): Manor Care Health Services
4b. City, Town, or Location of Death: Rossville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-24-2502
6. Sex: 1☐ M 2☒ F
7. Aga (In yrs. last birthday): 87 Yrs.
If Undar 1 Yaar: Months; Days
If Undar 24 Hrs.: Hours; Min.
8. Dete of Birth (Month, Day, Year): November 25, 1909
9. Birthplace (State or Foreign Country): West Virginia

Usual Residance of Decedant

10e. Stata: Maryland
10b. County: Baltimore
10c. City, Town or Location: Parkville
10d. Insida City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 2506 Creighton Avenue
10f. Zip Code: 21234
10g. Citizen of Whet Country?: United States
11. Meritel Status: 1☐ Navar Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Give Yeer or Datas:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:
14. Raca - Amarican Indian, Black, Whita, atc. Specify: White
15. Decedent's Education (Specify only highest grada complatad): Elamantary/Secondary (0-12): 11; Collaga (1-4or 5+):
16a. Decedent's Usual Occupetion (Give kind of work dona during most of working lifa. DO NOT usa ratired): Homemaker
16b. Kind of Businass/Industry: Own Home
17. Fathar's Nama (First, Middla, Last): Norman Lester Small
18. Mothar's Nama (First, Middla, Maidan Surnama): Anna Lou Rhodes
19a. Informant's Name/Ralationship (Type, Print): Mrs. Louanna J. Horney / Daughter
19b. Mailing Addrass (Straat and Numbar or Rural Route Number, City or Town, Stata, Zip Coda): 2506 Creighton Avenue Parkville, MD 21234
20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from Stata 4☐ Donetion 5☐ Othar (Specify)
20b. Place of Disposition (Nama of cematary, cramatory or othar place): Gardens of Faith
Data: June 7,1997
20c. Location - City or Town, Stata: Overlea, Maryland
21. Signatura of Funaral Service Licensaa: Paul F. Hartsock
22. Nama and Addrass of Facility: Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, MD 21214

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0029

permit. Pages 1 and 2 should be filed with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural" or "Pending investigation" or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Entar tha diseese, or complications that causad the daath. Do not antar tha mode of dying, such es cardiac or respiretory errest, shock, or haart failura. List only one causa on aach lina.

Approximeta intarval Batween Onset and Death

Immedieta Causa (Final disaase or condition resulting in death): a. COPD — years

Due to (or es e consequence of):

Sequantially list conditions, if any, laading to immadiata cause. Entar Underlying Cause (Diseese or injury that initiated evants resulting in death) Last:

b.

Dua to (or as a consequence of):

c.

Dua to (or as e consequance of):

d.

Part ii. **Other significant conditions** contributing to death but not rasulting in the underlying causa givan in Part I.: CAD, Dementia

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Ware autopsy findings evailable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was casa referred to medical examiner? 1☐ Yes 2☒ No

28. Placa of Daath (Check only ona): Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA; Othar: 4☒ Nursing Home 5☐ Residanca 8☐ Othar (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarminad

28e. Dete of injury (Month, Day Year)

28b. Tima of Injury

28c. injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Place of injury - At homa, farm, straat, factory, office building, atc. (Specify)

28f. Location (Streat and Number or Rural Route Number, City or Town, Stata)

29a. Cartifiar (Check only one): 1☒ **Certifying Physician:** To tha best of my knowledge, deeth occurred at tha tima, date and place, and due to the cause(s) end manner es steted. 2☐ **Medical Examiner:** On tha basis of examination end/or investigation, in my opinion, daath occurred at tha tima, date and placa, end due to the cause(s) and mannar statad.

29b. Signeture snd titla of certifier: Howard Dreelands MD

29c. Licansa number: D28127

29d. Data signed (Month, Day, Year): 6-5-97

30. Neme and addrass of person who compliated cause of deeth (item 23e) (Type, Print)

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

31. Data filed (Month, Day, Year): JUN 09 1997

32. Registrar's Signature: Gloria Davidson-Randall

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

97-3082-510
B.K.S
CLAUDE KELLY

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17066

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: CLAUDE KELLY
2. Deta of Death Month: JUNE Dey: 6, Year: 1997
3. Tima of Death: 0958 AM
4a. Facility Nama *(If not institution, giva street and number)*: 1511 NORTH RUTLAND AVENUE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Sacurity Number: 213-09-0420
6. Sax: 1☐M 2☐F — 1 X
7. Aga *(In yrs. last birthday)*: 80 Yrs. — If Undar 1 Yaar: Months / Deys; If Undar 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: AUG.16.1916
9. Birthplaca *(Stata or Foreign Country)*: SOUTH CAROLINA

Usual Residence of Decedent

10a. Steta: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☐Yes 2☐No — 1 X
10e. Street and Number: 1511 NORTH RUTLAND AVENUE
10f. Zip Code: 21213
10g. Citizen of Whet Country?: U.S.A.

11. Meritel Status: 1☐ Nevar Married 2☐ Married 3☐ Widowed 4☐ Divorced — 3 X
12. Was Decedent Evar In U.S. Armed Forces? 1☐Yas 2☐No — 2 X — If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puarto Rican, etc.) 1☐Yes 2☐No — 2 X — Specify:
14. Rece - Amarican Indian, Black, White, atc. Specify: NEGRO

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 6TH; Collega (1-4or 5+): N/A
16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: BLAST FURNACE OPERATOR
16b. Kind of Businass/Industry: BETHLEHEM STEEL CO.

17. Fether's Neme *(First, Middle, Last)*: WALTER KELLY
18. Mothar's Nama *(First, Middle, Maidan Sumame)*: MAGGIE JONES

19e. Informent's Name/Relationship *(Type, Print)*: CHRISTINE PARKER-daughter
19b. Mailing Addrass *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 815 N. LINWOOD AVE. BALTO, MD. 21205

20e. Mathod of Disposition: 1☒ Buriel 2☐Cremation 3☐Removal from State 4☐Donetion 5☐Othar *(Specify)*
20b. Placa of Disposition *(Name of cemetery, cremetory or other piece)*: BALTIMORE CEMETERY
Date: JUNE 13, 1997
20c. Location - City or Town, Stete: BALTO, MD.

21. Signature of Funeral Service Licensee: Calvin B. Scruggs, Sr.
22. Nama and Address of Facility: CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON STREET, BALTO, MD. 21213

Physician /Medical Examiner

23a. Part1. Entar the disaase, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heert feilura. List only one cause on each line. — Approximate Intarvel Batween Onsat and Death

Immadiate Cause (Finel disaase or condition resulting in daeth): e. Arteriosclerotic Cardiovascular Disease

Due to (or es e consequance of):

Sequentielly list conditions, if eny, leeding to immadiate cause. Enter Underlying Ceuse (Disaese or injury thet initieted events rasulting in deeth) Lest:
b. Due to (or es a consequence of):
c. Dua to (or es e consequenca of):
d.

Part Ii. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.: Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? INSPECTION 1☐Yes XX No
24b. Wera autopsy findings availabla prior to complation of causa of deeth? 1☐Yes 2☐No

25. Wes casa referred to medical examinar? XX Yes 2☐ No

26. Place of Death *(Check only ona)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Homa XX Rasidence 6☐ Other *(Specify)*

27. Manner of Death: X — 1☐ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be datarminad
28e. Deta of injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐Yas 2☐No
28d. Describe how injury occurred
28a. Place of injury - At home, farm, straet, fectory, offica building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☐ **Certifying Physician**: To the best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as statad. XX **Medical Examinar**: On the basis of exemination end/or investigetion, in my opinion, daeth occurred et the tima, data and place, and due to the ceuse(s) end menner steted.

29b. Signature and title of certifier: J. Laron Locke M.D.
29c. License number: O.C.M.E
29d. Data signed *(Month, Dey, Year)*: JUNE 6, 1997

30. Neme and eddress of person who completed causa of daeth (Item 23a) (Type, Print): J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed *(Month, Day, Year)*: JUN 09 1997
32. Registrar's Signeture: Julie Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17067

Physician /Medical Examiner

1. Decedent's Nema *(First, Middle, Last)*: Gregory T. Lawson

2. Dete of Deeth Month Dey Yeer: June 2, 1997

3. Time of Death: 11:00a.m

4e. Facility Nama *(If not institution, give street and number)*: Prince George's General Hospital

4b. City, Town, or Location of Death: Cheverly

4c. County of Deeth: P.G.

Funeral Director

5. Sociel Security Number: 578-94-4782

6. Sax: 1 [X] M 2 [ ] F

7. Aga *(In yrs. lest birthday)*: 32 Yrs. If Under 1 Yaar: Months / Deys. If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Yeer)*: Jan.24,1965

9. Birthplece *(Stete or Foreign Country)*: DC

Usuel Residance of Decedent

10e. Stata: MD

10b. County: PG

10c. City, Town or Location: Hyattsville

10d. Insida City Limits: 1 [ ] Yas [X] No

10e. Street and Number: 5104 Kenilworth Ave.

10f. Zip Code: 20781

10g. Citizen of What Country?: USA

11. Maritel Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yas 2 [X] No If Yes, Giva Yaar or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, atc.) 1 [ ] Yes [X] No *Specify:*

14. Rece - Amarican Indien, Black, White, atc. *Specify:* Black

15. Decedent's Education *(Specify only highest grada completed)*: Elemantery/Secondery (0-12): ; College (1-4or 5+): 1

18a. Decedent's Usuel Occupetion *(Give kind of work dona during most of working life. DO NOT use retired)*: Laboratory Technician

16b. Kind of Business/Industry: Private Industry

17. Fether's Neme *(First, Middle, Last)*: Walter Lawson, Sr.

18. Mother's Neme *(First, Middle, Meldan Surname)*: Sandra V. Magruder

19a. Informent's Name/Reletionship *(Type, Print)*: Marcellus Magruder/brother

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 5746 Colorado Ave.NW Washington, D.C.20011

20e. Mathod of Disposition: [X] Burial 2 [ ] Cremation 3 [ ] Removal from Stata 4 [ ] Donetion 5 [ ] Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Harmony Memorial Pk

Deta: 6/11

20c. Locetion - City or Town, Stete: Landover, MD

21. Signature of Funerel Service Licensee: R. N. Horton

22. Neme end Address of Facility: R.N. Horton Funeral Home 600 Kennedy St. Washington, D.C. 20011

Baltimore, Maryland 21218-0020

permit. Pages 1 and 2 should be filed with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or if item 23a or 28a-f show any injury or other traumatic event, the medical examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not entar tha mode of dying, such es cerdiac or respiratory errest, shock, or heert failure. List only one ceuse on eech line.

Approximate Interval Between Onset and Deeth

Immedieta Ceuse (Finel diseese or condition resulting in deeth)

e. acquired immune dyficency syndrome — unkn

Dua to (or as e consequence of):

Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury thet Initieted events resulting in deeth) Lest

b.

Due to (or es e consequence of):

c.

Due to (or es e consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

pneumocystis carinii pneumonia, renal failure, anemia, diarrhea, multiple wasting syndrome, depression

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was cese referred to medical exeminer? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Mennar of Deeth: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Panding investigation 6 [ ] Could not be datarmined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rurel Routa Number, City or Town, State)*

29a. Cartifiar *(Check only one)*: 1 [X] **Certifying Physician:** To tha bast of my knowladga, daath occurrad at tha time, date end place, and dua to tha causa(s) and mannar as stated. 2 [ ] **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, deeth occurred et tha tima, data end piece, and due to the ceusa(s) and manner stated.

29b. Signatura and title of certifier:

29c. License number: D01499

29d. Dete signed *(Month, Dey, Yaar)*: June 6, 1997

30. Neme and address of person who completed cause of daath (Item 23a) (Type, Print): Prince Georges Hospital Cheverly, MD

State Registrar

31. Dete filed *(Month, Dey, Yaar)*: JUN 09 1997

32. Registrar's Signature:

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17068

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN LOVELL

2. Date of Death Month: JUNE Day: 04 Year: 1997

3. Time of Death: 11:52 AM

4a. Facility Name (If not institution, give street end number): Union Memorial Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 261-58-2499

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 57 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Apr. 6, 1940

9. Birthplace (State or Foreign Country): Florida

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore County

10c. City, Town or Location: Parkville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street end Number: 7108 Chambers Road

10f. Zip Code: 21234

10g. Citizen of Whet Country?: USA

11. Maritel Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indien, Bleck, White, etc. Specify: White

15. Decadent's Education (Specify only highest grede completed)

Elementery/Secondery (0-12):

College (1-4or 5+): 4 yrs

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Architect

16b. Kind of Business/Industry: Retail Department Store

17. Fether's Name (First, Middle, Lest): John Lovell

18. Mother's Neme (First, Middle, Meiden Surneme): Mary Martha Gardner

19a. Informent's Neme/Reletionship (Type, Print): Mary Sue Lovell (Wife)

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 7108 Chambers Road, Parkville, MD 21234

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removel from State 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Piece of Disposition (Name of cemetery, cremetory or other piece): Green Mount Cemetery

Dete: 6/9/97

20c. Location - City of Town, Stete: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Martin D. Lawson

22. Name end Address of Feciility: Mitchell-Wiedefeld Home 6500 York Road, Baltimore, MD 21212

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complicetions thet caused the death. Do not enter the mode of dying, such es cardiec or respiretory efrest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immediate Ceuse (Finel diseese or condition resulting in deeth)

e. VENTRICULAR FIBRILLATION 2° TO ISCHEMIC — 5 WKS

Due to (or es e consequence of):

b. CARDIOMYOPATHY — 5 WKS

Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in deeth) Last

Due to (or es a consequence of):

c.

Due to (or es a consequenca of):

d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENTION, CHRONIC OBSTRUCTIVE PULMONARY DISEASE, CORONARY ARTERY DISEASE, RENAL FAILURE

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes an eutopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings aveileble prior to completion of cause of deeth? 1 [ ] Yes 2 [X] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Piece of Deeth (Check only one): Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Deeth: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2 [ ] **Medical Examiner:** On the basis of examinetion end/or Investigation, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) end manner steted.

29b. Signature and title of certifier:

29c. License number: AT 2438946-ASO

29d. Dete signed (Month, Dey, Year): JUNE 04, 1997

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): PAUL R. LUCAS, M.D. UNION MEMORIAL HOSP. BALTIMORE, MD

State Registrar

31. Dete filed (Month, Day, Year): JUN 09 1997

32. Registrar's Signature: Gina Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17069

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Catherine Loker
2. Dete of Death Month / Day / Yeer: June 4 1997
3. Time of Death: 3:50 pm
4a. Facility Neme *(If not institution, give street and number)*: Stella Maris Hospice
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 559-14-7507
6. Sex: 1☐ M 2☐ F XXX
7. Age *(In yrs. last birthdey)*: 82 Yrs. — If Under 1 Yeer: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Yeer)*: March 20, 1915
9. Birthplece *(State or Foreign Country)*: New York

Usuel Residence of Decedent

10a. Stete: Maryland
10b. County: Baltimore
10c. City, Town or Location: Towson
10d. Inside City Limits: 1☐ Yes 2☐ No XXX
10e. Street end Number: 2300 Dulaney Valley Road
10f. Zip Code: 21204
10g. Citizen of What Country?: USA

11. Meritel Stetus: 1☐ Never Merried 2☐ Merried XXX Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes XXX No If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes XXX No *Specify:*
14. Rece - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12) / College (1-4or 5+): 4
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Sales Agent
16b. Kind of Business/Industry: Real Estate

17. Fether's Neme *(First, Middle, Last)*: Patrick Joseph Kenny
18. Mother's Neme *(First, Middle, Meiden Surname)*: Mary Gibson

19a. Informant's Neme/Relationship *(Type, Print)*: F. Ford Loker Jr Son
19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4908 Carroll Manor Road Baldwin Md 21013

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☒ Donetion 5☐ Other *(Specify)*
20b. Plece of Disposition *(Name of cemetery, cremetory or other place)*: Dulaney Valley — Dete: 6/7/97
20c. Location - City or Town, State: Lutherville, Maryland

21. Signature of Funeral Service Licensee: Dennis O'Kenake
22. Neme end Address of Feciility: Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Pert1. Enter the disease, or compiiecetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one cause on eech line.

Approximete Interval Between Onset and Death

Immediate Ceuse (Finel diseese or condition resulting in deeth):
e. Adeno Carcinoma of Anus

Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in deeth) Lest:
b. Chronic Anemia due to Rectal Bleeding

Due to (or as e consequence of):
c.

Due to (or es e consequence of):
d.

Pert II. **Other significent conditions** contributing to deeth but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably XXX Unknown

24a. Wes an eutopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No
26. Plece of Deeth *(Check only one)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Dete of Injury *(Month, Dey Yeer)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medicel Examiner**: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner steted.

29b. Signeture end title of certifier: Eddie Nakhuda M.D.
29c. License number: D 15504
29d. Date signed *(Month, Day, Yeer)*: 6-5-97

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): Eddie Nakhuda, M.D. 2300 Dulaney Valley Rd., Timonium, Md. 21093

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: JUN 09 1997
32. Registrar's Signeture: Judie Davidson Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17070

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Irvin M. Little Jr.
2. Dete of Daath — Month: June Day: 3 Yeer: 1997
3. Time of Deeth: 08:05
4a. Feciity Name (If not Institution, give street and number): University of Maryland Medical System
4b. City, Town, or Location of Deeth: Baltimore
4c. County of Death: N/A

Funeral Director

5. Sociel Security Number: 218-42-5941
6. Sex: 1☐M 2☐F — XX
7. Age (In yrs. lest birthday): 52 Yrs. — If Under 1 Yaar: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Day, Year): 11-10-44
9. Birthplece (Stete or Foreign Country): Md.

Usuel Residence of Decedent

10e. Stete: Md
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 654 Melvin Drive
10f. Zip Code: 21230
10g. Citizen of What Country?: USA
11. Marital Status: 1☐ Naver Merried 2☐ Married 3☐ Widowed 4☐ Divorced — XX
12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yas 2☒ No — If Yes, Give Yaer or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Ricen, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: Black
15. Decedent's Eduestion (Specify only highest grede completed): Elementary/Secondary (0-12): 8th Grade; College (1-4or 5+): NA
16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Machine Operator
16b. Kind of Businass/Industry: Various Trades
17. Fether's Name (First, Middle, Last): Irvin M. Little, Sr.
18. Mother's Name (First, Middle, Maiden Surneme): Ollie Purvis
19e. Informent's Neme/Relationship (Type, Print): Ollie Little
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 420 Watty Court Baltimore, Maryland 21220
20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Remoyel from Stata 4☐ Donetion 5☐ Other (Specify) — XX
20b. Pleca of Disposition (Neme of cemetery, cremetory or other piece): King Mem. Pk. cem. Dete: 06-07-97
20c. Location - City or Town, Stete: Randallstown, Md.
21. Signetura of Funerel Service Licensee: ▶ Karen M. Kozer
22. Nama and Addrass of Facility: Baltimore, Maryland WM.C March FH 1101 E. North Avenue 21202

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural" or "pending investigation," or if item 28a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23e. Pert1. Enter the diseese, or complicetions that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heert failure. List only one cause on eech line. — Approximete Intervel Between Onset and Death

Immediete Ceuse (Final diseese or condition resulting in deeth):
e. Pneumonia — 6 weeks

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest:
b. Human Immunodeficiency (AIDS)

Due to (or es e consequence of):
c. Abuse of Heroin, Cocaine — 21 years

Due to (or es e consequence of):
d.

Pert II. **Other eignificant conditions** contributing to death but not resulting in the underlying cause given in Pert I.: Renal Failure; Poor nutrition

23b. **Did tobacco use contribute to the ceuse of deeth?** 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings aveileble prior to compietion of cause of deeth? 1☐ Yes 2☒ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Piece of Deeth (Check only one): Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Homa 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the cause(s) end menner es steted. 2☐ **Medical Examiner:** On the besis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) end menner stated.

29b. Signature end title of certifier: ▶ [signature] MD

29c. License number: D0051972

29d. Dete signed (Month, Dey, Year): June 3, 1997

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Richard Lamson 22 S. Greene Street Baltimore, Maryland 21201

State Registrar

31. Deta filed (Month, Day, Yeer): JUN 0 9 1997

32. Registrar's Signature: [signature] Debra Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

97 17071

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDEHT'S HAME (First, Middle, Last): EDITH LIGHTNER				2. DATE OF DEATH (Month, Day, Year): June 4 1997	3. TIME OF DEATH: 11:20PM M
4. SOCIAL SECURITY HUMBER: 212-74-1428	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 92 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): June 7, 1904	8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY HAME (If not institution, give street and number): Manor Care - Ruxton Nursing Home			9b. CITY, TOWN OR LOCATIOH OF DEATH: Towson		9c. COUHTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Towson	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ HO
10e. STREET AND NUMBER: 7001 North Charles Street		10f. ZIP CODE: 21204	10g. CITIZEN OF WHAT COUHTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDEHT EVER IH U.S. ARMED FORCES? 1 ☐ YES 2 ☒ HO IF YES, GIVE WAR OR DATES	13. WAS DECEHDEHT OF HISPAHIC ORIGIH? (Specify Yes or Ho— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDEHT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSIHESS/IHDUSTRY: Own Home	
17. FATHER'S NAME (First, Middle, Last): George Karmrodt		18. MOTHER'S HAME (First, Middle, Maiden Surname): Hattie Angstadt	
19a. IHFORMAHT'S HAME (Type/Print): Ralph G. Lightner (Son)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3141 Edgewood Road Ellicott City, Maryland 21043	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Lorraine Park Cemetery DATE: June 9, 1997	20c. LOCATION — City or Town, State: Woodlawn, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICEHSEE: R. Clay Witzke		22. NAME AHD ADDRESS OF FACILITY: Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue Catonsville, MD 21228	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CARCINOMA of BREAST DUE TO (OR AS A COHSEQUEHCE OF):	5 yrs.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A COHSEQUEHCE OF):	
	c. DUE TO (OR AS A COHSEQUEHCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AH AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ HO	24b. WERE AUTOPSY FINDIHGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☒

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ HO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	
27. MAHHER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF IHJURY (Month, Day, Year) / 28b. TIME OF IHJURY M / 28c. IHJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW IHJURY OCCURED	
	28e. PLACE OF IHJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYIHG PHYSICIAH: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMIHER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: A.H. Ghiladi MD	29c. LICEHSE NUMBER: D-12849	29d. DATE SIGHED (Month, Day, Year): ▶ 6-5-97
30. HAME AND ADDRESS OF PERSOH WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): A.H. GHILADI, M.D. 7600 OSLER Dr. TOWSON, Md 21204		
31. DATE RECEIVED BY REGISTRAR (Month, Day, Year): JUN 0 9 1997		

DHMH-16 Rev 1/89

WRC
97-3062-005
RUTH ANN
McCORMICK

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17072

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: RUTH ANN McCORMICK
2. Data of Daath — Month: JUNE Day: 05, Yaar: 1997
3. Tima of Death: 2:12 PM.
4a. Facility Nama *(If not institution, giva straat and number)*: 24 SIDEWELL CT.
4b. City, Town, or Location of Death: ESSEX
4c. County of Death: Baltimore

Funeral Director

5. Social Security Numbar: 215-30-9535
6. Sax: 1☐ M 2☒ F
7. Aga *(In yrs. last birthday)*: 64 Yrs.
If Undar 1 Yaar — Months: Days:
If Undar 24 Hrs. — Hours: Min.:
8. Data of Birth *(Month, Day, Yaar)*: Oct. 15, 1932
9. Birthplaca *(Stata or Foreign Country)*: Maryland

Usual Rasidance of Dacadant

10a. Stata: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Insida City Limits: 1☒ Yas 2☐ No
10e. Street and Number: 5203 Carter Avenue
10f. Zip Coda: 21214
10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1☐ Navar Marriad 2☐ Marriad 3☐ Widowad 4☒ Divorcad
12. Was Dacadant Evar in U.S. Armad Forcas? 1☐ Yas 2☒ No — If Yas, Giva Yaar or Datas:
13. Was Dacadant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*
14. Race - Amaricen Indian, Black, White, atc. *Specify:* White

15. Decadant's Education *(Specify only highast grada complatad)*: Elementary/Secondary (0-12): 12 years; College (1-4or 5+):
16a. Dacadant's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT use retired)*: Author
16b. Kind of Businass/Industry: Literary

17. Fathar's Nama *(First, Middla, Last)*: James Herold McCormick
18. Mothar's Nama *(First, Middla, Maidan Surnama)*: Margaret Mary Duffy

19a. Informant's Name/Relationship *(Type, Print)*: Lisa Verger (daughter)
19b. Mailing Address *(Straat and Number or Rural Route Number, City or Town, State, Zip Coda)*: 5203 Carter Avenue Baltimore, Maryland 21214

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*
20b. Place of Disposition *(Nama of camatary, crametory or othar placa)*: Holy Cross Cemetery
Data: 6-9-97
20c. Location - City or Town, Stata: Brooklyn, Maryland

21. Signatura of Funaral Sarvica Licansaa: George J. Ferrane
22. Nama and Address of Facility: Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart failure. List only ona causa on aach lina.

Approximata Intarval Batwaan Onsat and Death

Immadiata Ceusa (Final disaasa or condition rasulting in daath)
a. Arteriosclerotic Cardiovascular Disease

Sequentially list conditions, if any, leading to immadiata cause. Entar Undarlying Causa (Disaasa or injury thet initiated events rasulting in daath) Last
b. Due to (or as a consaquance of):
c. Due to (or as a consaquance of):
d. Due to (or as a consaquance of):

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying cause givan in Part I.

23b. Did tobacco usa contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? INSPECTION 1☐ Yas 2☒ No
24b. Wara autopsy findings available prior to compiation of causa of daath? 1☐ Yas 2☐ No

25. Was casa refarrad to medical examinar? 1☒ Yas 2☐ No
26. Plece of Death *(Check only ona)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA; Othar: 4☐ Nursing Homa 5☒ Rasidance 6☐ Othar *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding Investigation 6☐ Could not be datarminad
28a. Data of Injury *(Month, Day Yaar)*:
28b. Tima of Injury:
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurrad:
28e. Plece of Injury - At homa, farm, straat, factory, offica building, atc. *(Spacify)*:
28f. Location *(Streat and Number or Rural Routa Number, City or Town, Stata)*:

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledga, daath occurrad at tha tima, data and place, and dua to tha causa(s) and manner as stated. 2☒ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurrad at tha tima, data and place, and due to tha ceuse(s) and manner stated.
29b. Signatura and titla of certifiar:
29c. Licansa number: O.C.M.E.
29d. Data signed *(Month, Day, Yaar)*: JUNE 06, 1997

30. Nama and addrass of parson who completed causa of daath (Item 23a) (Type, Print): David Fowler, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed *(Month, Day, Yaar)*: JUN 09 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17073

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EDWARD EMERSON MURRAY

2. Data of Death Month / Day / Yaar: June 5 1997

3. Tima of Death: 2225

4a. Facility Nama (If not institution, giva street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Deeth: WICOMICO

Funeral Director

5. Social Security Number: 212-20-2425

6. Sax: 1☒M 2☐F

7. Age (In yrs. last birthday): 77 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): Aug. 1, 1919

9. Birthplaca (Stata or Foraign Country): Balto.Md.

Usual Rasidance of Dacedant

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Murray Hill

10d. Inside City Limits: 1☐Yas 2☒No

10e. Street end Number: 6400 Murray Hill Road

10f. Zip Coda: 21212

10g. Citizan of What Country?: USA

11. Marital Status: 1☐Naver Married 2☒Marriad 3☐Widowed 4☐Divorcad

12. Was Dacedant Evar in U.S. Armed Forcas? ☒Yas 2☐No If Yas, Give Yaar or Datas: 1941-45

13. Was Decedant of Hispenic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 1☐Yas 2☒No Spacify:

14. Race - Amarican Indian, Black, White, etc. Specify: White

15. Decedent's Education (Spacify only highast grada complated): Elementary/Secondary (0-12) / College (1-4or 5+): 5+

16a. Decedent's Usual Occupetion (Giva kind of work dona during most of working life. DO NOT use ratired): attorney

16b. Kind of Business/Industry: Law

17. Fathar's Nama (First, Middla, Last): John Edward Murray

18. Mothar's Name (First, Middla, Maiden Sumama): Norma Cumming

19a. Informant's Nama/Ratationship (Type, Print): Mrs. Frances J.Murray-wife

19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, State, Zip Coda): 6400 Murray Hill Road Balto.Md. 21212

20a. Mathod of Disposition: 1☐Burial 2☒Cramation 3☐Ramoval from Stata 4☐Donation 5☐Othar (Specify)

20b. Place of Disposition (Nama of camatary, cramatory or othar placa): Greenmount Cem. Crematory Date: 6/9/97

20c. Location - City or Town, Stata: Balto.Md.

21. Signatura of Funaral Sarvica Licensee: John D. Mitchell IV

22. Nama and Address of Facility: Mitchell-Wiedefeld Home, Inc. 6500 York Road, Balto.Md. 21212

Physician /Medical Examiner

23a. Part I. Entar tha disaase, or complications that caused the death. Do not antar the moda of dying, such es cardiac or respiretory arrast, shock, or heart failura. List only one ceuse on aach line.

Immedieta Causa (Final diseasa or condition rasulting in death): a. Pneumonia — Approximata Intervel Batween Onsat and Deeth: 2 days

Dua to (or as e consequanca of):

b. Multiple Myeloma — 1 year

Sequantially list conditions, if any, laading to Immadiata causa. Entar Undarlying Cause (Disasa or Injury that initieted avants resulting in daath) Last

Dua to (or as a consaquance of):

c.

Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa given in Part I.: CARCINOMA OF PROSTATE

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yas 2☒No

24b. Wara autopsy findings aveilable prior to compiation of causa of death? 1☐Yes 2☐No

25. Wes casa rafarred to madical axaminar? 1☐Yas 2☒No

26. Place of Death (Check only ona): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Othar: 4☐Nursing Homa 5☐Residanca 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicida 4☐Homicida 5☐Panding Investigation 6☐Could not be datarmined

28a. Data of Injury (Month, Day Yaar)

28b. Tima of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Dascribe how injury occurred

28e. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurred at tha tima, data and placa, and due to tha causa(s) and manner stated.

29b. Signatura and titla of cartifiar: Allen W. Justin, M.D.

29c. Licansa number: D27996

29d. Data signed (Month, Day, Year): June 5, 1997

30. Nama and address of person who complated cause of death (Item 23a) (Type, Print): Allen W. Justin, M.D. 105 Pine Bluff Rd., Ste 7A, Salisbury, MD 21801

State Registrar

31. Data filed (Month, Day, Year): JUN 09 1997

32. Registrar's Signature: Sheila Davidson-Randalls

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

EDWARD E. MURRAY

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item24a 6-9-97 FilmG748 W.H.Per Doctor

Certificate of Death

Reg. No. 97 17074

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY A. MYERS
2. Data of Death: Month 04 Dey 26 Year 97
3. Time of Death: 1051 AM
4a. Facility Name (If not institution, give street and number): SINAI HOSPITAL
4b. City, Town, or Location of Death: BALTO, CITY
4c. County of Death: —

Funeral Director

5. Social Security Number: 212-26-7593
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Year): Jan. 5, 1910
9. Birthplace (State or Foreign Country): unknown

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore City
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1217 W. Fayette Street
10f. Zip Coda: 21215
10g. Citizen of What Country: U.S.A.

11. Marital Status: unknown — 1☐ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? unknown — 1☐ Yas 2☐ No If Yes, Give Yeer or Dates:
13. Was Dacedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puerto Ricen, etc.) — 1☐ Yas 2☒ No Specify:
14. Race - American Indian, Bleck, White, etc. — Specify: Black

15. Decedent's Educetion (Specify only highest grede completed)
Elementary/Secondary (0-12): unknown
College (1-4or 5+): unknown
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unknown
16b. Kind of Business/Industry: unknown

17. Father's Name (First, Middle, Last): unknown
18. Mother's Name (First, Middle, Meiden Surneme): unknown

19a. Informant's Name/Relationship (Type, Print): Evelyn Chew/neice
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 1705 Gertrude Street, Baltimore, Maryland 21206

20a. Mathod of Disposition: 1☐ Buriel 2☐ Cremation 3☐ Removel from Stata 4☐ Donetion 5☒ Other (Specify): in state
20b. Placa of Disposition (Neme of cemetery, crematory or other piece)
Data
20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or raspiratory arrast, shock, or heart feilure. List only one cause on each line.

Approximate Intervel Between Onsat and Death

Immediate Ceuse (Finel disease or condition resulting in death): e. ASCVD — unknown

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events rasulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

Diabetes
Hypertension
Dementia
Dysphagia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes cese referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete and plece, end due to the cause(s) and menner as steted. 2☐ **Medical Examiner:** On the besis of examinetion and/or investigetion, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) end manner stated.

29b. Signature and title of certifier
29c. License number: D27569
29d. Dete signed (Month, Dey, Year): 5/6/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Allen Heffernan 1838 Greene Tree Rd #300

State Registrar

31. Date filed (Month, Dey, Year): JUN 09 1997
Registrar: Linda Williamson Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that tha death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funerel director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17075

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Cora Morris

2. Date of Death: Month 06 Day 02 Year 97

3. Time of Death: 6:35 p.m.

4a. Facility Name (If not institution, give street and number): Johns Hopkins Hospital-Bayview

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: NA

Funeral Director

5. Social Security Number: 213-28-5847

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 91 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 01-01-06

9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 4940 Eastern Avenue

10f. Zip Code: 21224

10g. Citizen of What Country? USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): UNKNOWN

College (1-4or 5+): NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer

16b. Kind of Business/Industry: various trades

17. Father's Name (First, Middle, Last): UNKNOWN

18. Mother's Name (First, Middle, Maiden Surname): UNKNOWN

19a. Informant's Name/Relationship (Type, Print): Deborah Hamilton

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 861 Park Avenue Baltimore, Maryland 21201

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Voshell Mem. Gardens

Date: 06-09-97

20c. Location - City or Town, State: Dundalk, Md.

21. Signature of Funeral Service Licensee: Annette K. Jones

22. Name and Address of Facility: Baltimore, Maryland 21202

WM.C. March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Pneumonia	10 Days
Due to (or as a consequence of): b.	Metastatic Breast Cancer	2 months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer's Disease

Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jeremy Walston MD

29c. License number: D38849

29d. Date signed (Month, Day, Year): 6/3/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jeremy Walston MD JHGC 5505 Bayview Circle Balto, MD 21224

State Registrar

31. Date filed (Month, Day, Year): JUN 09 1997

32. Registrar's Signature: Lisa Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed with the local registrar of death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than natural, or if the 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17076

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Anne Marie Merson

2. Data of Death Month JUNE Day 4, Year 1997

3. Time of Death: 2:33 PM

4a. Facility Name *(If not institution, give street and number)*: THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE CITY

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-78-2754

6. Sex: 1☐ M 2☒ F

7. Aga *(In yrs. last birthday)*: 36 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 9/5/60

9. Birthplaca *(State or Foraign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: BALTIMORE

10c. City, Town or Location: RIDGELEIGH

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Numbar: 1719 RED OAK ROAD

10f. Zip Code: 21234

10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedant Ever in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- It Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - Amaricen Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Educetion *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 2 years

16a. Dacedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SECRETARY

16b. Kind ot Business/Industry: STATE OF MARYLAND JUVENILE JUSTICE

17. Father's Name *(First, Middle, Last)*: WILLIAM H. MERSON

18. Mother's Name *(First, Middle, Maiden Surnama)*: VERONICA H. HUPKA

19a. Informant's Name/Relationship *(Type, Print)*: VERONICA H. MERSON MOTHER

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1717 RED OAK ROAD BALTIMORE, MD 21234

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: PARKWOOD CEMETERY

Date: 6/7/97

20c. Location - City or Town, State: BALTIMORE, MD

21. Signatura of Funeral Service Licensaa: Christine A Kopczynski

22. Nama and Address of Facility: JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD. TOWSON, MD 21286

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode ot dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onsat and Death

Immediate Cause (Final disease or condition resulting in death): a. CARDIOMYOPATHY — 2 MONTHS

Due to (or as a consequence ot):

Saquentially list conditions, if any, leading to immediata ceuse. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Dua to (or as a consequance of):

d.

Part II. **Other eignificant conditione** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobecco use contribute to the cauee of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings availabla prior to completion of ceusa of death? 1☐ Yas 2☒ No

25. Was cese referred to medical examiner? 1☐ Yes 2☒ No

26. Place ot Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner ot Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece ot Injury - At home, tarm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Phyeician:** To the best ot my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and manner as steted. 2☐ **Medical Examiner:** On the basis ot examinetion end/or investigetion, in my opinion, death occurred et the time, dete and place, and due to the cause(s) and manner stated.

29b. Signatura and title ot certifiar: Peter J. Gruber MD

29c. License number: RES-000

29d. Date signed *(Month, Day, Year)*: June 4, 1997

30. Name and address ot person who completed cause ot death (Item 23e) (Type, Print): Peter J. Gruber MD Johns Hopkins Hospital

State Registrar

31. Date tiled *(Month, Day, Year)*: JUN 09 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural" or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17077

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JOSEPH O. PALMER

2. Date of Death Month / Day / Year: MAY 27 1997

3. Time of Death: 11:23pm

4a. Facility Name *(If not institution, give street and number)*: Bon Secour Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 216-10-8877

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 94 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 3, 1903

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore City

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 701 Arlington Avenue

10f. Zip Code: 21217

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6; College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: unknown

16b. Kind of Business/Industry: unknown

17. Father's Name *(First, Middle, Last)*: unknown

18. Mother's Name *(First, Middle, Maiden Surname)*: unknown

19a. Informant's Name/Relationship *(Type, Print)*: unknown

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: unknown

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade

22. Name and Address of Facility: Ronald S. Wade, Director State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Congestive heart failure — Due to (or as a consequence of): — 4 years

b. Hypertension — Due to (or as a consequence of): — 11

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic Renal failure

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Bich T. Duong MD

29c. License number: D26256

29d. Date signed *(Month, Day, Year)*: 5/28/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BICH T. DUONG, MD 700 Washington Blvd Baltimore MD 21230

State Registrar

31. Date filed *(Month, Day, Year)*: JUN 09 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Medical Certification: To be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17078

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): ANNIE PATTERSON

2. Dete of Deeth — Month: JUNE Dey: 7 Year: 1997

3. Time of Deeth: 04:20AM

4a. Fecility Neme (If not institution, give street end number): Good Samaritan Hospital

4b. City, Town, or Location of Deeth: Baltimore

4c. County of Deeth: N/A

Funeral Director

5. Social Security Number: 219-32-2603

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. lest birthday): 74 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Yeer): August 2,1922

9. Birthplece (State or Foreign Country): S.C.

Usuel Residence of Decedent

10e. Stete: MD.

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 2951 Clifton Avenue

10f. Zip Code: 21216

10g. Citizen of Whet Country?: U.S.A.

11. Marital Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.): 1☐ Yes 2☐ No Specify:

14. Rece - American Indien, Bleck, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 11th Grade; College (1-4or 5+):

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Housekeeping Supervisor

16b. Kind of Business/Industry: Spring Grove State Hospital

17. Fether's Neme (First, Middle, Last): Henry Jones

18. Mother's Neme (First, Middle, Meiden Surneme): Mary

19e. Interment's Neme/Relationship (Type, Print): Husband Benjamin A. Patterson JR.

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 2951 Clifton Avenue Baltimore, MD. 21216

20a. Method of Disposition: 1☐ Buriel 2☐ Cremation 3☐ Removel from State 4☐ Donetion 5☒ Other (Specify) Entombment

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Arbutus Memorial Park

Dete: June 11

20c. Location - City or Town, Stete: Baltimore County, MD.

21. Signeture of Funerel Service Licensee: Ernest R. Emry, IV

22. Neme end Address of Fecility: Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, MD. 21216

Physician /Medical Examiner

23a. Pert I. Enter the diseese, or complications thet cause the deeth. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heert tailure. List only one ceuse on each line.

Approximete Interval Between Onset end Deeth

Immediete Cause (Finel disease or condition resulting in death): e. SEPSIS

Due to (or es a consequence of):

Sequentially list conditions, if eny, leeding to immediete ceuse. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in death) Lest:

b.

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Wes cese referred to medicel exeminer? 1☐ Yes 2☒ No

26. Plece of Deeth (Check only one): Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer):

28b. Time of Injury: M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, term, street, tactory, office building, etc. (Specify):

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the beeis of exemination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: Adriana Andrade, MD

29c. License number: P10579

29d. Dete signed (Month, Dey, Yeer): June 7, 1997

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Adriana Andrade, MD Good Samaritan Hospital 3601 Loch Raven Boulevard Baltimore, MD 21239

State Registrar

31. Dete filed (Month, Dey, Yeer): JUN 09 1997

32. Registrer's Signeture: Lavidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours of death with the Maryland Department of Health end Mental Hygiene. **Important: If Item 27 is marked other than "Neturel" or "Pending investigation" or 28a-f show any injury or other traumatic event, the Medical Exeminer must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items24a,28a-28c 6-9-97 FilmG748 W.H.Per Doctor

Certificate of Death

Reg. No. 97 17079

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BARBARA PRYBA
2. Date of Death: Month June Day 4 Year 1997
3. Time of Death: 1:25 pm
4a. Facility Name (If not institution, give street and number): St. Agnes Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 256-56-6977
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 59 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 30, 1938
9. Birthplace (State or Foreign Country): Georgia

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 707 Hunting Place
10f. Zip Code: 21229
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nurse
16b. Kind of Business/Industry: Health Care

17. Father's Name (First, Middle, Last): Charles Scheider
18. Mother's Name (First, Middle, Maiden Surname): Alva Hirt

19a. Informant's Name/Relationship (Type, Print): Ronald Pryba (Husband)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 707 Hunting Place Baltimore, MD 21229

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Catholic Cemetery
Date: June 11, 1997
20c. Location - City or Town, State: Savannah, Georgia

21. Signature of Funeral Service Licensee: Richard Timm
22. Name and Address of Facility: Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue Catonsville, Maryland 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Sepsis	2 wks
Due to (or as a consequence of):	b. necrotizing fasciitis of sacrum	2 wks.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c. Renal failure	
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Liver Cirrhosis; Rheumatoid arthritis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year): 6/4/97
28b. Time of Injury: 1:25 PM
28c. Injury at Work? 1☐ Yes 2☑ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Bryan Khim, MD
29c. License number: D50978
29d. Date signed (Month, Day, Year): 6/4/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Bryan Khim, MD 2850 N. Ridge Road, Suite 103 Ellicott City, MD 21043

State Registrar

31. Date filed (Month, Day, Year): JUN 09 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Division of Vital Records, State Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17080

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: NANCY STAFFORD ROTH
2. Date of Death Month Day Year: May 31, 1997
3. Time of Death: 4:20PM
4a. Facility Name *(If not institution, give street and number)*: OAK CREST RETIREMENT COMMUNITY
4b. City, Town, or Location of Death: Parkville
4c. County of Death: Baltimore County

Funeral Director

5. Social Security Number: 216-46-2207
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 87 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June 26, 1909
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore County
10c. City, Town or Location: Parkville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8830 Walther Blvd.
10f. Zip Code: 21234
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 yrs; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Residence

17. Father's Name *(First, Middle, Last)*: Joseph Patrick Stafford
18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Jane McEvoy

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Margaret M. Krach (Niece)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9300 Mediterrain Drive, Ocean City, MD 21842

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Most Holy Redeemer Cem.
Date: 6/3/97
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Martin D. Lawson
22. Name and Address of Facility: Mitchell-Wiedefeld Home, 6500 York Road, Baltimore, MD 21212

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Complete Heart Block — 72 Hrs.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number: D50620
29d. Date signed *(Month, Day, Year)*: 6/1/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): B. Zable, M.D., 8800 Walther Blvd. Parkville, MD 21231

State Registrar

31. Date filed *(Month, Day, Year)*: JUN 09 1997
32. Registrar's Signature: Julie Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

20

Item23PartII 6-9-97 FilmG748 W.H.Per Doctor

.97 17081

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): William Anthony Reeder
2. DATE OF DEATH (Month, Day, Year): 5/5/97
3. TIME OF DEATH: 330am M
4. SOCIAL SECURITY NUMBER: 578-48-2361
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 58 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 8/8/38
8. BIRTHPLACE (State or Foreign Country): Wash DC
9a. FACILITY NAME (If not institution, give street and number): Cuppett & Weeks N H
9b. CITY, TOWN OR LOCATION OF DEATH: Oakland Md
9c. COUNTY OF DEATH: Garrett

RESIDENCE OF DECEDENT

10a. STATE:
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Washington DC
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 3708 Ely Pl SE #202
10f. ZIP CODE: 20019
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11th — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Maintenance
16b. KIND OF BUSINESS/INDUSTRY: Commerical
17. FATHER'S NAME (First, Middle, Last): William D. Reeder
18. MOTHER'S NAME (First, Middle, Maiden Surname): Doris L. Newman
19a. INFORMANT'S NAME (Type/Print): Patricia A Hill
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3708 Ely Pl SE Wash DC #202 20019
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Forest Hills Cem — DATE: 5/14/97
20c. LOCATION — City or Town, State: Clinton Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Roger J Mayer
22. NAME AND ADDRESS OF FACILITY: Sterling Funeral Service 1601 Kenilworth Ave NE Wash DC 20019

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. urinary tract infection	1 day
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

~~diabetes mellitus, quadraparesis, aphasia and aphagia due to old closed head trauma~~ Quadraplegia,Diabetes Mellitus

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [X] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Walter K Naumann M.D.
29c. LICENSE NUMBER: D25759
29d. DATE SIGNED (Month, Day, Year): May 5, 1997
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Walter K. Naumann, M.D., PO Box 247, 106 Cemetery Road, Accident MD 21520
31. DATE FILED (Month, Day, Year): JUN 09 1997
REGISTRAR'S SIGNATURE: Jisha Davidson-Kongslee

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17082

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Lest): MARY C. REICHELT

2. Date of Deeth — Month: JUNE Dey: 05 Yeer: 1997

3. Time of Deeth: 8:40AM

4e. Feclity Neme (If not institution, give street end number): The Good Samaritan Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Deeth: N/A

Funeral Director

5. Social Security Number: 212-58-0872

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthdey): 95 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Yeer): April 18,1902

9. Birthplece (Stete or Foreign Country): Pennsylvania

Usuel Residence of Decedent

10e. State: Maryland

10b. County: Harford

10c. City, Town or Location: Belair

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 700 Rosefield Court

10f. Zip Code: 21014

10g. Citizen of Whet Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Ricen, etc.): 1☐ Yes 2☒ No Specify:

14. Rece - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 8 — College (1-4or 5+):

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Fether's Neme (First, Middle, Last): Robert Thomas

18. Mother's Neme (First, Middle, Meiden Surneme): Margaret McGrath

19e. Informent's Name/Reletionshlp (Type, Print): Mr. Richard R. Reichelt,Sr./ Son

19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code): 700 Rosefield Court Belair, Maryland 21014

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other place): New Cathedral Cemetery

Dete: 6/7/97

20c. Location - City or Town, Stete: Baltimore, Maryland

21. Signeture of Funeral Service Licensee: Mark T. Zavoyna — Mark T. Zavoyna

22. Neme end Address of Feclity: Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed with the Funeral Director within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications that ceused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Death

Immediate Ceuse (Finel diseese or condition resulting in deeth): e. SEPSIS — APPROX. 7 DAYS

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in death) Lest

b. Due to (or es e consequence of):

c. Due to (or es e consequence of):

d.

Pert II. **Other elgnificent conditlone** contributing to death but not resulting in the underlying ceuse given in Pert I.

HISTORY OF CONGESTIVE HEART FAILURE, CHRONIC OBSTRUCTIVE PULMONARY DISEASE

23b. Did tobacco uee contribute to the cauee of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Was en eutopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings eveileble prior to completion of ceuse of death? 1☐ Yes 2☑ No

25. Wes cese referred to medical exeminer? 1☐ Yes 2☑ No

26. Place of Deeth (Check only one): Hospital: 1☑ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☑ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28e. Date of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Phyelcian:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the besis of exemination end/or Investigetion, In my opinion, death occurred et the time, date and place, end due to the ceuse(s) end manner stated.

29b. Signeture end title of certifier: Mayalupta M.D.

29c. License number: D0051197

29d. Date signed (Month, Day, Yeer): JUNE 5th 1997

30. Neme end eddress of person who completed ceuse of deeth (Item 23a) (Type, Print): MAYA GUPTA GOOD SAMARITAN HOSPITAL

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Dete filed (Month, Day, Yeer): JUN 09 1997

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17083

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Roland Richardson
2. Date of Death Month Day Year: 5-20-97
3. Time of Death: 8pm
4a. Facility Name (If not institution, give street and number): University of Maryland Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 215-26-2557
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 67 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 25, 1930
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Dorchester
10c. City, Town or Location: Cambridge
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 701 Race Street #326
10f. Zip Code: 21613
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: Oct 1950-53
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4 or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): painter
16b. Kind of Business/Industry: private
17. Father's Name (First, Middle, Last): Charlie Deacon Richardson
18. Mother's Name (First, Middle, Maiden Surname): Mary Alice Horseman
19a. Informant's Name/Relationship (Type, Print): Mary Richardson/wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 701 Race Street, #326, Cambridge, Maryland 21613
20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place):
Date:
20c. Location - City or Town, State:
21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Esophageal Cancer — 1 month
Due to (or as a consequence of):
b. Status post lung biopsy — 5 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Coronary Artery Disease
Peripheral Vascular Disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No
25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year):
28b. Time of Injury: M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred:
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify):
28f. Location (Street and Number or Rural Route Number, City or Town, State):
29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D47906
29d. Date signed (Month, Day, Year): 5/20/97
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): G. MASSOGLIA University of Maryland, Baltimore.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): JUN 09 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17084

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: RUTH DOROTHY RODRIGUEZ

2. Date of Death — Month: May; Day: 28; Year: 1997

3. Time of Death: 8:00 PM

4a. Facility Name *(If not institution, give street and number)*: Dulaney-Towson Nursing Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 172-09-1000

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 93 Yrs.

If Under 1 Year — Months: ; Days: ; If Under 24 Hrs. — Hours: ; Min.:

8. Date of Birth *(Month, Day, Year)*: Dec. 19, 1903

9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Towson

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 111 West Rd.

10f. Zip Code: 21204

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): Unknown; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Laborer

16b. Kind of Business/Industry: Pottery

17. Father's Name *(First, Middle, Last)*: John Madden

18. Mother's Name *(First, Middle, Maiden Surname)*: Frances Madden

19a. Informant's Name/Relationship *(Type, Print)*: Frances Madden

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 12 E. Burke Ave., Towson, MD 21286

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Moreland Memorial Park

Date: 5/31/97

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: ALTENBURG FUNERAL HOME, P.A. 6009 Harford Rd., Baltimore, MD 21214

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Anorexia — 3-4 months

Due to (or as a consequence of):
b. Dementia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Bashar Karakash, M.D.

29c. License number: D 47813

29d. Date signed *(Month, Day, Year)*: May 30 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): BASHAR KARAKASH 3007 E. Northern Parkway Baltimore MD 21214

State Registrar

31. Date filed *(Month, Day, Year)*: JUN 0 9 1997

32. Registrar's Signature: [signature] Sheila Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17085

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Della Sorrentino

2. Data of Death: Month: May; Day: 31; Year: 1997

3. Time of Death: 9:45 PM

4a. Facility Name *(If not institution, give street and number)*: Merridian Nursing Center-Loch Raven

4b. City, Town, or Location of Death: Baynesville

4c. County of Death: Baltimore County

Funeral Director

5. Social Security Number: 214-12-8039

6. Sex: 1 [X] M 2 [ ] F

7. Aga *(In yrs. last birthday)*: 83 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: Feb 25, 1914

9. Birthplaca *(Stata or Foraign Country)*: Oklahoma

Usual Rasidanca of Decedent

10a. Stata: Maryland

10b. County: Baltimore County

10c. City, Town or Location: Baynesville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Straat and Number: 8720 Emge Road

10f. Zip Coda: 21234

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Nevar Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedant Evar in U.S. Armed Forcas? 1 [ ] Yas 2 [X] No If Yas, Give Yaar or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - Americen Indian, Black, White, etc. *Specify:* White

15. Decedant's Education *(Specify only highest grada complated)*: Elamentary/Secondary (0-12): 8 yrs; Collega (1-4or 5+):

16a. Decedant's Usual Occupation *(Giva kind of work done during most of working lifa. DO NOT use retired)*: Homemaker

16b. Kind of Businass/Industry: Own Residence

17. Fathar's Nama *(First, Middle, Last)*: Frank O. Costa

18. Mother's Nema *(First, Middle, Maiden Sumama)*: Maria Greico

19a. Informant's Name/Ralationship *(Type, Print)*: Mauro F. Sorrentino

19b. Mailing Addrass *(Straat and Number or Rural Route Number, City or Town, Stata, Zip Code)*: 425 E. Belvedere Avenue, Balto., MD 21212

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Othar *(Specify)*

20b. Place of Disposition *(Name of cematary, cramatory or othar place)*: Most Holy Redeemer Cem. Data: 6/4/97

20c. Location - City or Town, State: Baltimore, Maryland

21. Signatura of Funaral Sarvica Licensee: Martin D. Lawson

22. Nama and Address of Facility: Mitchell-Wiedefeld Home, 6500 York Road, Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that caused tha daath. Do not entar the moda of dying, such as cardiac or respiratory arrast, shock, or haart failura. List only ona causa on each line.

Approximata Intarval Between Onset and Death

Immediata Ceusa (Final disaasa or condition rasulting in death)

a. Aspiration — Approximata Intarval: 2 months

Dua to (or as a consequanca of):

b. Encephalopathy

Dua to (or as a consequanca of):

Sequantially list conditions, if any, leading to immadiate cause. Entar Underlying Causa (Disaase or injury thet initiated evants rasulting in death) Last

c. Cerebral Anoxia

Dua to (or as a consequanca of):

d.

Part II. **Other significant conditiona** contributing to daath but not rasulting in the underlying cause givan in Part I.

23b. Did tobacco uae contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Wera autopsy findings available prior to complation of causa of death? 1 [ ] Yas 2 [ ] No

25. Was casa rafarred to medical examinar? 1 [ ] Yas 2 [X] No

26. Placa of Death *(Check only ona)*: Hospital: 1 [ ] Inpatiant 2 [ ] ER/Outpatient 3 [ ] DOA; Othar: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Neturel 2 [ ] Accidant 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Dascribe how injury occurred

28a. Place of Injury - At home, farm, straat, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifier *(Check only one)*: 1 [X] **Certifying Physician:** To tha bast of my knowladge, deeth occurred at tha tima, deta and place, and dua to tha causa(s) and manner as steted. 2 [ ] **Medical Examiner:** On the basis of axamination and/or invastigetion, in my opinion, deeth occurred at tha tima, data and placa, and dua to tha causa(s) and manner stated.

29b. Signatura and title of certifier: Bashar Karakash, M.D.

29c. License number: D 47813

29d. Date signed *(Month, Day, Year)*: June 1 1997

30. Nema and addrass of person who complated cause of death (Itam 23a) (Type, Print): BASHAR KARAKASH 3007 E. Northern Parkway Baltimore MD 21214

State Registrar

31. Data filad *(Month, Day, Year)*: JUN 09 1997

32. Registrar's Signature: Gloria Harrison-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that tha deeth certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

RB

4

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17086

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Phillip Shellington

2. Date of Death: Month June Day 02 Year 1997

3. Time of Death: 08:25 am

4a. Facility Name (If not institution, give street end number): Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-52-7317

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 47 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): MAR. 12, 1950

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD.

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 317 E. NORTH AVE.

10f. Zip Code: 21202

10g. Citizen of What Country?: U.S.A

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Rece - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grede completed)

Elementary/Secondary (0-12): 12TH

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CONSTRUCTION

16b. Kind of Business/Industry: BUILDING

17. Father's Name (First, Middle, Last): SAMUEL RICHARDSON

18. Mother's Name (First, Middle, Maiden Surname): PAYLIS SHELLINGTON

19a. Informant's Name/Relationship (Type, Print): ELLA BESSICK

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 608 COOK LANE APT. 202 BALT, MD. 21229

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): KING MEM PK. Date: 6/7/97

20c. Location - City or Town, State: RANDALLSTOWN MD.

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: GARY P. THOMAS FUNERAL HOME P.A. 270 FREDHILTON PASS BALT, MD. 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): a. Retroviral Syndrome — Approximate Interval: years

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Renal failure, Recurrent Bacterial Pneumonia

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigetion 6 ☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner es steted. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: ▶ B Kirkpatrick MD

29c. License number: 00653

29d. Date signed (Month, Dey, Year): 6/2/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): B KIRKPATRICK BAYVIEW MEDICAL CENTER EASTERN AVE BALTIMORE MD

State Registrar

31. Date filed (Month, Dey, Yeer): JUN 09 1997

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21218-2020

permit. Pages 1 and 2 should be filed within 24 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or "accident" or if there is any injury or other traumatic event, the medical examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17087

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): THOMAS E. SCHUYLER
2. Date of Death: Month June Day 1st Year 1997
3. Time of Death: 6:20 PM
4a. Facility Name (If not institution, give street and number): MERCY HOSPITAL
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

Funeral Director

5. Social Security Number: 219-50-2913
6. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthday): 49 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11-6-47
9. Birthplace (State or Foreign Country): MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☑ Yes 2 ☐ No
10e. Street and Number: 3018 Chelsea Terr.
10f. Zip Code: 21216
10g. Citizen of What Country? USA

11. Marital Status: 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9th grade; College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: Raymond Steel Co.

17. Father's Name (First, Middle, Last): Russel Schuyler, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Pauline Gaines

19a. Informant's Name/Relationship (Type, Print): Pauline Schuyler
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5 Brett Ct. Apt 330 Baltimore, MD 21221

20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Holly Hills CEM
Date: 6-5-97
20c. Location - City or Town, State: White Marsh, MD

21. Signature of Funeral Service Licensee: Lee V. Holland
22. Name and Address of Facility: March F.H. East 1101 E. Noth Ave.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dytng, such as cardiac or respiretory errest, shock, or heart failure. Ltst only one cause on eech line.

		Approximate Interval Between Onset and Death
Immediate Cause (Ftnal disease or condition resulting tn death) a.	acute pulmonary embolism suspected	5 minues
Due to (or as a consequence of): b.	pulmonary hypertension	10 yrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting tn death) Last — Due to (or as a consequence of): c.	Ventilatory dependent Respiratory failure	2 mths
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Phyaician:** To the best of my knowledge, death occurred at the time, date and piece, end due to the cause(s) and menner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, tn my opinion, death occurred at the time, date and piece, end due to the ceuse(s) end manner stated.
29b. Signeture end title of certifier
29c. License number: D30494
29d. Date signed (Month, Day, Year): 6/2/97

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print): [illegible] 611 south Charles street Deatn medical center Baltimore MD 21229

State Registrar

31. Date filed (Month, Day, Year): JUN 09 1997
32. Registrar's Signature: [illegible]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death within Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 25a or 25b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17088

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Dolly Mae Simon

2. Date of Death — Month: June Day: 06 Year: 97

3. Time of Death: 4:37am

4a. Facility Name *(If not institution, give street and number)*: 6505 Laurelton Avenue

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: NA

Funeral Director

5. Social Security Number: 262-34-7114

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 63 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 09-23-33

9. Birthplace *(State or Foreign Country)*: S.C.

Usual Residence of Decedent

10a. State: Md

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 6505 Laurelton Avenue

10f. Zip Code: 21214

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): 12th Grade — College (1-4or 5+): NA

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Floor Personal

16b. Kind of Business/Industry: Acme Pad Corp.

17. Father's Name *(First, Middle, Last)*: Willie Draft

18. Mother's Name *(First, Middle, Maiden Surname)*: Essie Summers Draft

19a. Informant's Name/Relationship *(Type, Print)*: Paul Simon

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6505 Laurelton Avenue Baltimore, Md. 21214

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Moreland Mem. Pk. Cem — Date: 06-10-97

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: ▶ Karen M. Kotz

22. Name and Address of Facility: Baltimore, Maryland 21202 — WM.C. March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Metastatic Small Cell Lung Carcinoma — 20 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)* — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Charles Padgett MD

29c. License number: D15546

29d. Date signed *(Month, Day, Year)*: June 6, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Charles Padgett MD, 5601 Loch Raven Blvd., Baltimore, MD 21239

State Registrar

31. Date filed *(Month, Day, Year)*: JUN 09 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours of death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items17,18 6-9-97 FilmG748 W.H.Per F/H

Certificate of Death

Reg. No. 97 17089

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Tevin J. Spencer

2. Date of Death: Month 6 Day 3 Year 97

3. Time of Death: 12 55 AM

4a. Facility Name (If not institution, give street and number): University of Maryland Med. System.

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-31-7741

6. Sex: 1 X M 2 ☐ F

7. Age (In yrs. last birthday): 6 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 12-29-90

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 X Yes 2 ☐ No

10e. Street and Number: 120 S. Mount St.

10f. Zip Code: 21223

10g. Citizen of What Country? USA.

11. Marital Status: 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black.

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): Pre-K; College (1-4or 5+): NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Student

16b. Kind of Business/Industry: Child

17. Father's Name (First, Middle, Last): Charles D. Spencer ~~Spencer, Charles~~

18. Mother's Name (First, Middle, Maiden Surname): Teresa A. Betts ~~Betts, Teresa~~

19a. Informant's Name/Relationship (Type, Print): Teresa Betts

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 120 S. Mount St. Baltimore, MD 21223

20a. Method of Disposition: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): OAKLAWN CEM

Date: 6-6-97

20c. Location - City or Town, State: Dundalk, MD

21. Signature of Funeral Service Licensee: Lynette K. Jones

22. Name and Address of Facility: March F.H East 1101 E. North Ave

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardio Pulmonary Arrest

Due to (or as a consequence of):

b. Acute Hepatitis + Pancreatitis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Progressive Renal Failure

Due to (or as a consequence of):

d. AIDS

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HIV Encephalopathy

Recurrent bacterial infections

Severe disorder

23b. **Did tobacco use contribute to the cause of death?** 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 X Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 X Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ✓ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Tevin Jones MD.

29c. License number: D39691

29d. Date signed (Month, Day, Year): June 3, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Peter Vink 225 Greene St. Baltimore MD 21210 University of Maryland Hosp.

State Registrar

31. Date filed (Month, Day, Year): JUN 09 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural" or if item 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item:5 per Physician G-748 6/13/97 reb

Certificate of Death

Reg. No. 97 17090

3060 Steen, Robert

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert LeRoy Steen

2. Date of Death: Month June Day ~~06~~ Year 1997

3. Time of Death: 6:50AM

4a. Facility Name (If not institution, give street and number): Fallston General Hospital

4b. City, Town, or Location of Death: Fallston

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 215-12-8760

6. Sex: 1☒M 2☐F

7. Age (In yrs. last birthday): 75 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 6 1921

9. Birthplace (State or Foreign Country): Maryland

Usual Residance of Decedent

10a. State: Md.

10b. County: Harford

10c. City, Town or Location: Bel Air

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 2060 Stratton Ct.

10f. Zip Code: 21015

10g. Citizen of What Country? USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): +4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mechanical Engineer

16b. Kind of Business/Industry: Defense

17. Father's Name (First, Middle, Last): Clifton LeRoy Steen

18. Mother's Name (First, Middle, Maiden Surname): Elva Florence Ehlers

19a. Informant's Name/Relationship (Type, Print): Robert W. Steen/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2060 Stratton Ct. Bel Air, Md. 21015

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Gardens Of Faith Cemetery

Date: 6-10-97

20c. Location - City or Town, State: Overlea, Md.

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", "not known", or "pending investigation", or if item 29 is marked "yes", the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. ASPIRATION PNEUMONIA — 1 WEEK

Due to (or as a consequence of):

b. RIGHT CEREBRAL INFARCT — 2 MONTHS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

BILATERAL OBSTRUCTIVE NEPHROPATHY

NON INSULIN DEPENDENT DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5+1

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Andrew Nowakowski MD

29c. License number: D08096

29d. Date signed (Month, Day, Year): JUNE 5, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANDREW NOWAKOWSKI MD, 125 N. MAIN ST. BELAIR, MD 21014

State Registrar

31. Date filed (Month, Day, Year): JUN 09 1997

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item10e 6-6-97 FilmG748 W.H.Per A. Board

Certificate of Death

Reg. No. 97 17091

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Alvin Thomas Smith

2. Dete of Deeth — Month: June Dey: 1 Yeer: 1997

3. Time of Death: 9:10 AM

4e. Feciity Neme (If not institution, give street end number): Stella Maris Hospice at Mercy

4b. City, Town, or Location of Deeth: Baltimore

4c. County of Deeth: Baltimore City

Funeral Director

5. Social Security Number: 212-20-8391

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthdey): 71 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Yeer): May 21, 1926

9. Birthplece (Stete or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore City

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: ~~5746 Bker Street~~ 5746 Baker Street

10f. Zip Code: 21216

10g. Citizen of Whet Country? U.S.A.

11. Marital Stetus: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Detes: 1944-56

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Rece - American Indien, Black, White, etc. Specify: Black

15. Dacedant's Eddcetion (Specify only highest grede completad)

Elemantary/Secondery (0-12): 12

Collega (1-4or 5+): 2

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use ratired): Teacher

16b. Kind of Business/Industry: School

17. Fethar's Neme (First, Middle, Last): Frank Abrams

18. Mother's Name (First, Middle, Meiden Surneme): Admonia Elizabeth Foard Smith

19e. Informant's Neme/Reletionship (Type, Print): Joseph Smith/brother

19b. Mailing Address (Stret and Number or Rural Route Number, City or Town, Stete, Zip Code): 3609 W. Forest Park Avenue, Baltimore, Maryland 21216

20e. Mathod of Disposition: 1☐ Burial 2☐ Cremetion 3☐ Removal from State 4☒ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cramatory or other piece)

Date

20c. Location - City or Town, Stete

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Neme end Addrass of Fecility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23e. Part1. Enter the diseese, or complicetions thet caused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heert failure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immediete Ceusa (Finel diseese or condition resulting in death): e. Cancer of head and neck — unknown

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated evants resulting in deeth) Last:

b. Due to (or es e consequence of):

c. Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying cause given in Pert t.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24e. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveileble prior to complation of ceusa of deeth? 1☐ Yes 2☐ No

25. Wes cese referrad to medicel exeminer? 1☐ Yes 2☒ No

26. Piece of Deeth (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice Stella Maris at Mercy

27. Manner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Streat end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To tha bast of my knowledga, daath occurred et the time, data end plece, end due to the ceuse(s) end mannar as steted. 2☐ **Medical Examiner**: On the basis of examinetion end/or investigetion, in my opinion, daeth occurred et the time, date and plece, and due to the ceuse(s) and menner stated.

29b. Signeture end title of certifier: ▶ M. Ramos

29c. License number: D40480

29d. Dete signed (Month, Day, Year): June 1, 1997

30. Neme and address of parson who complated cause of death (Item 23a) (Type, Print): FERNANDO J. FERRO, MD 5510 Belair Rd Balto, MD 21206

State Registrar

31. Dete filed (Month, Day, Year): JUN 06 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17092

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Joseph Sobierajski

2. Data of Death Month / Day / Year: June 4, 1997

3. Time of Death: 2:35 P.M.

4a. Facility Name *(If not institution, give street and number)*: Horizon Specialty Care at Canton Harbor

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-10-4238

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 3/13/1916

9. Birthplace *(State or Foreign Country)*: Indiana

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore City

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 134 N. Lakewood AVe.

10f. Zip Code: 21224

10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Dacedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.): 1☐ Yas 2☒ No *Specify:*

14. Raca - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): Unk. / College (1-4or 5+): Unk.

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Diesetter

16b. Kind of Business/Industry: Telephone

17. Father's Name *(First, Middle, Lest)*: Romuald Sobierajski

18. Mother's Name *(First, Middle, Meiden Surname)*: Stella Roman

19a. Informant's Name/Relationship *(Type, Print)*: Frances Sobierajski/Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 134 N. Lakewood AVe. Baltimore, MD 21224

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of camatery, crematory or other place)*: Gardens of Faith Cem.

Date: 6/7/97

20c. Location - City or Town, State: Baltimore Cnty., MD

21. Signature of Funeral Service Licensee: Bernard Dabrowski

22. Name and Address of Facility: B. Dabrowski & Son Funeral Home 2818 E. Baltimore St. Baltimore, MD 21224

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line.

Approximeta Intervel Between Onsat and Death

Immediate Cause (Finel disaase or condition resulting in death)
a. STROKE — 3 Days

Due to (or as a consequanca of):
b. ARTERIO Sclerosis VAscular Dimm — 4yrs

Sequantially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last
c. DEMENTIA — 4yr

Dua to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of causa of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Data of Injury *(Month, Day Yaar)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Exeminar:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatura and title of certifier:

29c. Licansa number: D24276

29d. Data signad *(Month, Day, Yaar)*: 6 6 97

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): SIMON SCALIA 2801 HUDSON ST BALTIMORE, MD 21224

State Registrar

31. Date filed *(Month, Day, Year)*: JUN 0 9 1997

32. Registrar's Signature: Lisa Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", 6, 7, items 28 or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

97-2962-510
CIP
UNKNOWN 97-120
VICTONIO SPENCER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Item:28a-f per MEO G-759 5/21/98 reb

Reg. No. 97 17093

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
VICTONIO SPENCER	MAY 31, 1997	11:19AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
WOODS ADJACENT TO 1900 BLOCK EAGLE DRIVE	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 1 Year Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-86-4584	1 X M 2 ☐ F	26 Yrs.					7-2-1970	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	BALTO. CO.	LANSDOWNE	1 ☐ Yes 2 X No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3915 MCDOWELL LANE	21227	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:	Specify: AFR. AMERICAN

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	2	BARBER	BARBER SHOP

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
HOWARD SPENCER	MARILYN FORD SPENCER

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MARILYN FORD (MOTHER)	3915 MCDOWELL LANE BALTO. MD 21227

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	MT. ZION CEM.	6/7/1997	LANSDOWNE MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PLACE BALTO. MD 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Gunshot wound of the Head	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequance of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 X Yes 2 ☐ No	1 X Yes 2 ☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 X Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) SCENE

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 X Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	found 5/31/97	found 11:15 A M	1 ☐ Yes 2 X No	Subject was shot

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
found: Wooded area adjacent to 1900 Blk. of Eagle Dr.	Leakin Park

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1 ☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 X **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Donald G Wright MD	O.C.M.E.	JUNE 1, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
DONALD G. WRIGHT MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 09 1997	[signature]

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or if item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

97-3092-510
AM
JANE
THOMAS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17094

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JANE M. THOMAS
2. Date of Death (Month, Day, Year): JUNE 06, 1997
3. Time of Death: 10:27 P
4a. Facility Name *(If not institution, give street and number)*: 1717 N. WOLF ST.
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: n/a

Funeral Director

5. Social Security Number: 218-60-4046
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 77 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: JAN 6, 1920
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: n/a
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: XX 1☐ Yes 2☐ No
10e. Street and Number: 1717 N. WOLFE STREET
10f. Zip Code: 21213
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced XX
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 th; College (1-4or 5+): -
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: LABORER
16b. Kind of Business/Industry: unemployed

17. Father's Name *(First, Middle, Last)*: JOHN FAGAN
18. Mother's Name *(First, Middle, Maiden Surname)*: EMMA MADDOX

19a. Informant's Name/Raletionship *(Type, Print)*: DIANE CARTER-DAUGHTER
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2735 CHESLEY AVENUE, BALTO.,MD 21234

20a. Method of Disposition: 1☒ Burial XX 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: ARBUTUS MEMORIAL
Date: 6-11-97
20c. Location - City or Town, State: ARBUTUS, MD

21. Signature of Funeral Service Licensee: Gabrielle Cwp
22. Name end Address of Facility: WM. C. MARCHF H.-4300 WABASH AVENUE

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on aach line. — Approximate Interval Between Onsaf and Death

Immediate Cause (Final disease or condition resulting in death)
a. Blunt force injury of head or neck
Due to (or as a consequence of):

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequance of):
d.

Part II. **Other signiffcant conditiona** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Dfd tobecco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? XX 1☒ Yas 2☐ No
24b. Were autopsy findings available prior fo complation of cause of deeth? 1☒ Yes 2☐ No

25. Was cese referred to medicel axaminer? XX 1☒ Yes 2☐ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence X 6☐ Other *(Specify)*

27. Manner of Death: 1☐ Neturel 2☐ Accident 3☐ Suicida 4☒ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*: 6.6.97
28b. Time of Injury: UNK M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: Subj Ent beaten
28e. Place of Injury - At homa, farm, street, factory, office building, etc. *(Specify)*: Home
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: 1717 N. Wolf St. Balto

29e. Certifier *(Check only one)*: 1☐ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination end/or investigetion, in my opinion, deeth occurred at the time, date and place, end due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: Ann Dixon
29c. Licanse number: OCME
29d. Date signed *(Month, Day, Year)*: JUNE 07, 1997

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print): Ann Dixon, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JUN 09 1997
32. Registrar's Signature: Julia Purdon-Randalls

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or if there is any doubt, show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17095

Physician /Medical Examiner

1. Decadant's Neme *(First, Middle, Last)*: Callie Terry

2. Data of Death — Month: June; Day: 5; Year: 1997

3. Time of Death: 5:10 PM

4a. Facility Nama *(If not institution, giva street end number)*: Mercy Medical Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: NA

Funeral Director

5. Social Security Number: 212-56-6638

6. Sax: 1☐ M 2☐ F — xx

7. Age *(In yrs. last birthday)*: 56 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs: Hours / Min.

8. Data of Birth *(Month, Dey, Year)*: 09-15-40

9. Birthplace *(State or Foreign Country)*: VA

Usual Residence of Dacedent

10a. Stete: Md

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1724 East 28th Street

10f. Zip Coda: 21218

10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Giva Year or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yas 2☒ No *Specify:*

14. Race - Amarican Indian, Black, White, etc. *Specify:* Black

15. Decedant's Education *(Specify only highest grade completed)*: Elamantary/Secondary (0-12): 10th Grade; Collaga (1-4or 5+): NA

16a. Decedent's Usual Occupation *(Give kind of work dona during most of working lifa. DO NOT use retired)*: Disabled

16b. Kind of Businass/Industry: NA

17. Fathar's Name *(First, Middle, Last)*: Willie LEE Logan

18. Mother's Name *(First, Middle, Malden Surneme)*: Lucy Mae Terry

19a. Informant's Name/Relationship *(Type, Print)*: Thelma Terry

19b. Mailing Addrass *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 1724 East 28th Street Baltimore, Maryland 21218

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Ramoval from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Cedar Hill Cemetery

Data: 06-10-97

20c. Location - City or Town, State: Anne Arundel Co., Md.

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: Wm. C. March FH 1101 E. North Avenue Baltimore, Maryland 21202

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused tha daath. Do not enter tha mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line.

		Approximata Interval Between Onaat end Death
Immediate Causa (Final disease or condition resulting in daath) e.	Intracerebral Bleed.	3 days
Dua to (or as e consequence of):		
Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Causa (Diseese or Injury that initiated events resulting in daath) Last — b.	Hypertension	20 years
Dua to (or as a consequence of):		
c.		
Dua to (or as a consequence of):		
d.		

Part II. **Other stgnificant conditions** contributing to death but not rasulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Wara autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medicat examinar? 1☐ Yes 2☒ No

26. Place of Daath *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Homa 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, straat, factory, office building, etc. *(Specify)*

28f. Location *(Straat and Number or Rural Routa Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Phyaictan:** To the bast of my knowledge, death occurrad at the time, date and place, and dua to tha cause(s) and manner as stated. 2☐ **Medtcat Examtner:** On the basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and due to the causa(s) and manner stated.

29b. Signatura and title of certifier: ▶ Vijay Pethkar M.D

29c. Licanse number: D 50853

29d. Date signed *(Month, Dey, Year)*: June 5, 1997.

30. Nama and address of person who complated causa of daath (Item 23a) (Type, Print): Vijay Pethkar, 301 St. Paul Place, Baltimore MD 21202.

State Registrar

31. Date filed *(Month, Day, Year)*: JUN 09 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or if the case has been referred to the Medical Examiner, it must be reported at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17096

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Algie Taylor

2. Date of Death (Month, Day, Year): May 17, 1997

3. Time of Death: 7:26 AM

4a. Facility Name (If not institution, give street and number): Prince Georges Hospital

4b. City, Town, or Location of Death: Cheverly

4c. County of Death: Hyattsville

Funeral Director

5. Social Security Number: 578-70-8588

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 43 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 7/4/53

9. Birthplace (State or Foreign Country): unknown

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince Georges

10c. City, Town or Location: Bladensburg

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 4277 58th Avenue #7

10f. Zip Code: 20710

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? unknown 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondary (0-12): unknown

College (1-4or 5+): unknown

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unknown

16b. Kind of Business/Industry: unknown

17. Father's Name (First, Middle, Last): unknown

18. Mother's Name (First, Middle, Maiden Surname): unknown

19a. Informant's Name/Relationship (Type, Print): unknown

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): unknown

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) in state

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. massive GI bleed - DIC — 6 days

Due to (or as a consequence of):

b. esophageal varices — 6 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. cirrhosis — yrs

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Signature

29c. License number: D30318

29d. Date signed (Month, Day, Year): 5/19/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Demetrios Catevenis, Prince Georges Hospital

State Registrar

31. Date filed (Month, Day, Year): JUN 09 1997

32. Registrar's Signature: Tina Davidson-Randall

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17097

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: William Adolph WOELM JR.

2. Date of Death: Month June, Day 4, Year 1997

3. Time of Death: 5:30 A.M.

4e. Facility Name *(If not institution, give street and number)*: Franklin Square Hospital Center

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217-03-7849

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov 16, 1919

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore County

10c. City, Town or Location: Parkville

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 2610 Edgewood Avenue

10f. Zip Code: 21234

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 yrs | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Sheet Metal Worker

16b. Kind of Business/Industry: Atlas Sheet Metal Co.

17. Father's Name *(First, Middle, Last)*: William Adolph Woelm, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Sadie Gertrude McCafferty

19e. Informant's Name/Relationship *(Type, Print)*: Kathryn M. Woelm (Wife)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2610 Edgewood Avenue, Baltimore, Maryland 21234

20e. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Dulaney Valley Mem Grdns | Date: 6/6/97

20c. Location - City or Town, State: Timonium, Maryland

21. Signature of Funeral Service Licensee: Martin D. Lawson

22. Name and Address of Facility: Mitchell-Wiedefeld Home 6500 York Road, Baltimore, Maryland 21212

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Leukemia — 10 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Sideroblastic Anemia — 2 years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease

Valvular Heart Disease

Emphysema

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24e. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28e. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Marcus Zamora MD

29c. License number: D40819

29d. Date signed *(Month, Day, Year)*: June 4, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Dr. Marcus Zamora 9000 Franklin Square Drive Baltimore, Md. 21237

State Registrar

31. Date filed *(Month, Day, Year)*: JUN 09 1997

32. Registrar's Signature: Joan Davidson-Randall

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17098

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William C WILSON
2. Date of Death (Month, Day, Year): June 5, 1997
3. Time of Death: 11:35 P.M.
4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center
4b. City, Town, or Location of Death: Rosedale
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-30-1222
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 65 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): July 7, 1931
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 219 S. Eaton Street
10f. Zip Code: 21224
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: Korean
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): Unknown; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Machine Operator
16b. Kind of Business/Industry: Manufacturing

17. Father's Name (First, Middle, Last): William Calvin Wilson
18. Mother's Name (First, Middle, Maiden Surname): Louise Heigen

19a. Informant's Name/Relationship (Type, Print): Mrs. Gloria L. Wilson/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 219 S. Eaton Street Baltimore, MD 21224

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Meadowridge Mem. Pk. Cem.
Date: 6/10/97
20c. Location - City or Town, State: Dorsey, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic Lung Cancer — 6 Months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Gastrointestinal Bleeding

23b. **Did tobacco use contribute to the cause of death?** 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Marco Zamora, MD
29c. License number: D40819
29d. Date signed (Month, Day, Year): June 6, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Marco Zamora 9000 Franklin Square Drive Baltimore, Maryland 21237

State Registrar

31. Date filed (Month, Day, Year): JUN 09 1997
32. Registrar's Signature: Gina Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural" or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

97-3037-510
B.K.S
PATRICIA V. WATTS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17099

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): PATRICIA V. WATTS
2. Data of Death (Month, Day, Yaer): JUNE 4, 1997
3. Time of Death: 0446AM
4a. Facility Name (If not institution, giva street and number): BON SECOUR HOSPITAL E.R.
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

Funeral Director

5. Social Security Number: 217-40-9587
6. Sax: 1☐ M 2☒ F
7. Aga (In yrs. last birthday): 53 Yrs.
If Under 1 Yaar: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Yaer): JULY 27, 1943
9. Birthplaca (State or Foraign Country): BALTIMORE, MD

Usual Residance of Dacedant

10a. State: MARYLAND
10b. County:
10c. City, Town or Location: BALTIMORE
10d. Insida City Limits: 1☒ Yas 2☐ No
10e. Street and Number: 2716 KINSEY AVE.
10f. Zip Coda: 21223
10g. Citizan of Whet Country?: USA

11. Marital Status: 1☐ Naver Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:
13. Was Dacedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: AFRO. AMERICAN

15. Decadant's Education (Specify only highast grada completed): Elamentary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa retired): UNKNOWN
16b. Kind of Businass/Industry: UNKNOWN

17. Fathar's Nama (First, Middla, Last): PHILLIP TAYEE
18. Mothar's Nama (First, Middla, Maidan Sumama): EDNA JONES

19a. Informant's Name/Ralationship (Type, Print): MARY JONES
19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code): 2716 KINSEY AVE, BALTIMORE, MARYLAND 21223

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cematery, crametory or othar placa): MT. ZION CEMETERY
Data: 6/9/97
20c. Location - City or Town, Stata: PASADENA, MARYLAND

21. Signature of Funeral Service Licansee: Lloyd M. Estep
22. Name and Address of Facility: ESTEP BROTHERS FUNERAL HOME, P.A. 1300 EUTAW PLACE, BALTIMORE, MARYLAND 21217

Physician /Medical Examiner

23a. Part1. Entar the disaese, or complications that causad the daath. Do not entar the moda of dying, such es cardiac or respiretory errest, shock, or haart failura. List only one causa on each line.

Approximate Intarval Batween Onset end Death

Immediata Causa (Final disaasa or condition resulting in death): e. Hypertensive Arteriosclerotic Cardiovascular Disease

Dua to (or as a consaquance of):

Sequentially list conditions, if any, leading to immadiata cause. Entar Underlying Cause (Diseesa or Injury that initiated events resulting in daath) Last:
b.
Dua to (or as a consequance of):
c.
Dua to (or as a consaquanca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa givan in Part I.

23b. **Did tobecco use contribute to the ceuse of deeth?** 1☐ **Yes** 2☐ **No** 3☐ **Probably** 4☐ **Unknown**

24a. Wes an autopsy parformad? INSPECTION 1☐ Yes 2☒ No

24b. Wara autopsy findings available prior to completion of cause of deeth? 1☐ Yas 2☐ No

25. Was casa referred to medical examinar? 1☒ Yas 2☐ No

26. Placa of Death (Check only ona)
Hospital: 1☐ Inpatiant 2☒ ER/Outpatiant 3☐ DOA
Othar: 4☐ Nursing Homa 5☐ Rasidanca 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be detarmined

28a. Data of Injury (Month, Day Yaar)
28b. Tima of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Dascribe how injury occurred
28e. Placa of Injury - At homa, farm, straat, factory, office building, etc. (Specify)
28f. Location (Streat and Number or Rural Route Number, City or Town, Stete)

29a. Cartifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledga, daath occurred at the tima, data and placa, and due to the ceusa(s) and menner as steted. 2☒ **Medical Examiner:** On tha basis of axamination and/or investigetion, in my opinion, death occurred at the tima, data and place, and dua to tha causa(s) and mannar statad.

29b. Signatura and title of certifier: Theodore M. King M.D.
29c. Licansa number: O.C.M.E
29d. Data signed (Month, Day, Yaar): JUNE 4, 1997

30. Nema and addrass of person who completed causa of daath (Item 23a) (Type, Print): Theodore King M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed (Month, Day, Yaar): JUN 0 9 1997
32. Registrar's Signatura: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pagas 1 and 2 should be filed within 24 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural" or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet tha daath certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for usa as tha burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17100

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JENNIFER J. YOUNG

2. Dete of Deeth — Month: JUNE Dey: 01 Yeer: 1997

3. Time of Death: 11:51 (pm)

4e. Feclity Name (If not Institution, give street end number): THE GOOD SAMARITAN HOSPITAL OF MARYLAND, INC 5601 LOCH RAVEN BOULEVARD

4b. City, Town, or Location of Daeth: BALTIMORE

4c. County of Deeth: BALTIMORE

Funeral Director

5. Social Security Number: 220-52-3385

6. Sex: 1☐ M 2☑ F

7. Age (In yrs. last birthday): 52 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Deta of Birth (Month, Dey, Yeer): 9-30-44

9. Birthplece (State or Foreign Country): MD

Usuel Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☑ Yes 2☐ No

10e. Street end Number: 5406 Sagra Rd

10f. Zip Code: 21239

10g. Citizen of What Country: USA

11. Marital Status: 1☑ Never Merried 2☐ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No — If Yes, Give Yaar or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 1☐ Yes 2☑ No Specify:

14. Rece - Americen Indian, Bleck, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed) — Elementery/Secondery (0-12): 11th grade — College (1-4or 5+): NA

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Laborer

16b. Kind of Business/Industry: AAI Corp.

17. Fethar's Neme (First, Middle, Last): John B. Young

18. Mother's Neme (First, Middle, Maiden Surneme): Hester Mae Holloman

19e. Informant's Neme/Reletionship (Type, Print): Tricia Young

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 5406 Sagra Rd. Baltimore, MD 21239

20e. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removel from Stata 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Neme of camatery, cremetory or othar place): Voshell Mem Garden

Data: 6-6-97

20c. Location - City or Town, Steta: Dundalk, MD

21. Signature of Funeral Service Licensee: Lynette K. Jones

22. Name end Address of Feclity: March F. Ho EAST 1101 E. North Ave

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complicetions thet caused the deeth. Do not enter the moda of dying, such es cerdiec or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onsat and Deeth

Immediete Ceuse (Finel diseese or condition resulting in deeth)
e. SEPSIS — 5 DAYS

Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Entar Underlying Ceuse (Diseese or Injury thet initieted avents resulting in deeth) Last
b. ULCERATIVE COLITIS — 10 YEARS

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other eignificant conditione** contributing to death but not resulting in tha undertying ceuse givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings aveileble prior to completion of ceusa of deeth? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Piece of Deeth (Check only one) — Hospitel: 1☑ Inpatiant 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending Investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, offica building, etc. (Specify)

28f. Location (Streat and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1☑ **Certifying Phyaicien:** To the best of my knowledge, death occurred et the time, dete end place, end due to the ceuse(s) end mannar es steted. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) end menner steted.

29b. Signature end title of certifiar: Shaker Itani

29c. Licansa number: P10588

29d. Data signed (Month, Day, Year): JUNE 01 1997

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print): SHAKER ITANI, THE GOOD SAMARITAN HOSPITAL 5601 LOCH RAVEN BOULEVARD, BALTIMORE, MD, 21239

State Registrar

31. Dete filed (Month, Day, Year): JUN 0 9 1997

32. Registrer's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" (Items 28a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17101

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ASHER ZLOTNIK
2. Date of Death: Month May Day 29 Year 1997
3. Time of Death: 8:30 am
4a. Facility Name (If not institution, give street and number): Sinai Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: City

Funeral Director

5. Social Security Number: 040-16-5306
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 12, 1915
9. Birthplace (State or Foreign Country): Connecticut

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore City
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 6503 Park Heights Avenue
10f. Zip Code: 21215
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Professor
16b. Kind of Business/Industry: College

17. Father's Name (First, Middle, Last): Philip Zlotnik
18. Mother's Name (First, Middle, Maiden Surname): Annie Ackerman

19a. Informant's Name/Relationship (Type, Print): Roselyn Zlotnik/wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6503 Park Heights Avenue, Baltimore, Maryland 21215

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place)
Date
20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Sepsis

Due to (or as a consequence of):
b. Indwelling Foley catheter

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Incontinence

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Cerebrovascular accident

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: David Blass MD
29c. License number: AS 240232 1-089854
29d. Date signed (Month, Day, Year): May 29, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sinai Hospital of Baltimore

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): JUN 09 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17102

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): FRANCES Adler

2. Dete of Deeth — Month: MAY Dey: 20, Yeer: 1997

3. Time of Deeth: 12:15AM

4e. Fecility Neme (If not institution, give street and number): HOLY CROSS HOSPITAL

4b. City, Town, or Location of Deeth: SILVER SPRING

4c. County of Deeth: MONTGOMERY

Funeral Director

5. Sociel Security Number: 161-07-8846

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 79 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Day, Year): MAY 10, 1918

9. Birthplece (State or Foreign Country): PENNSYLVANIA

Usuel Residence of Decedent

10a. State: MARYLAND

10b. County: MONTGOMERY

10c. City, Town or Location: SILVER SPRING

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 15210 ELKRIDGE WAY #2A

10f. Zip Code: 20906

10g. Citizen of Whet Country?: UNITED STATES

11. Maritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Bleck, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondary (0-12): 12 — College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): SALE

16b. Kind of Business/Industry: WOMEN'S CLOTHING

17. Fether's Neme (First, Middle, Last): LARRY HORN

18. Mother's Name (First, Middle, Maiden Surneme): SARAH FELDMAN

19e. Informent's Name/Relationship (Type, Print): LINDA WEISS/DAUGHTER

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 6414 GOLDLEAF DRIVE, BETHESDA, MARYLAND 20817

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Plece of Disposition (Name of cemetery, cremetory or other plece): KING DAVID MEMORIAL GDNS

Dete: 5/22/97

20c. Location - City or Town, Stete: FALLS CHURCH, VIRGINIA

21. Signeture of Funeral Service Licensee: David C Strak

22. Neme end Address of Facility: Danzansky-Goldberg Memorial Chapels, Inc. 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23e. Part1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one ceuse on eech line.

Approximete Interval Between Onset end Death

Immediete Ceuse (Finel disease or condition resulting in death)

e. PULMONARY FAILURE — 1 wk

Due to (or es e consequenca of):

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury thet intieted events resulting in deeth) Lest

b. LUNG METASTASES — 4 mo

Due to (or es e consequence of):

c. LUNG CANCER

Due to (or es e consequence of):

d.

Part II. **Other eignificant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco uee contribute to the causa of death?** 1☑ **Yes** 2☐ **No** 3☐ **Probably** 4☐ **Unknown**

24a. Wes an eutopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings aveileble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☑ No

26. Plece of Deeth (Check only one) — Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, street, fectory, offica building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Medicai Certification: To Be Completed by Physician/Medical Examiner

29e. Certifier (Check only one) 1☑ **Certifying Phyaicien**: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner as steted. 2☐ **Medical Examiner**: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end placa, end due to the ceuse(s) end menner stated.

29b. Signeture end title of certifier: Stanley A Schwartz

29c. License number: D17368

29d. Date signed (Month, Dey, Year): 5/20/97

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): DR STANLEY A. SCHWARTZ, 2101 MEDICAL PARK DR, #210, SILVER SPRING, MD 20902-4000

State Registrar

31. Dete filed (Month, Dey, Year): MAY 22 1997

32. Registrar's Signature: Julia Davidson-Randall

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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DHMH 16 Rev 6/95

97-2473-033
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17103

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): DR. AYO D. ALABI
2. Dete of Deeth — Month: May Day: 6, Year: 1997
3. Time of Deeth: 2000p
4a. Facility Neme (If not institution, give street and number): 9122 EDMONSTON CT. #304
4b. City, Town, or Location of Deeth: GREENBELT
4c. County of Deeth: PRINCE GEORGES

Funeral Director

5. Social Security Number: 579-78-0053
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 50 Yrs. — If Under 1 Yeer: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Day, Year): JULY 1, 1946
9. Birthplece (State or Foreign Country): NIGERIA

Usuel Residence of Decedent

10a. Stete: MD
10b. County: PRINCE GEORGES
10c. City, Town or Location: GREENBELT
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street end Number: 9122 EDMONSTON CT. #304
10f. Zip Code: 20710
10g. Citizen of Whet Country?: UNITED STATES

11. Maritel Stetus: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indien, Bleck, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): — College (1-4or 5+): 5+
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): CAB DRIVER
16b. Kind of Business/Industry: TRANSPORTATION

17. Fether's Neme (First, Middle, Last): ALHAJI L. A. ALABI
18. Mother's Neme (First, Middle, Maiden Surname): MRS. SAFURATU ALABI

19a. Informent's Neme/Reletionship (Type, Print): ISIAKA ABIODUN ALABI (Brother)
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P. O. BOX 35127, HOUSTON, TX 77035

20a. Method of Disposition: 1 [X] Buriel 2 [ ] Cremation 3 [ ] Removel from Stete 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Piece of Disposition (Name of cemetery, crematory or other place): GEORGE WASHINGTON CEM.
Dete: 5/20/97
20c. Location - City or Town, Stete: ADELPHI, MD.

21. Signeture of Funerel Service Licensee: L. N. Horton
22. Neme end Address of Fecility: R. N. HORTON CO. MORTICIANS, INC. 600 KENNEDY STREET, NW, DC, 20011

Physician /Medical Examiner

23a. Pert I. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one ceuse on each line.

Approximete Intervel Between Onset and Death

Immediete Ceuse (Final diseese or condition resulting in deeth): e. Atherosclerotic Cardiovascular Disease

Due to (or as e consequence of):

Sequentielly list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in deeth) Lest

b.

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes an autopsy performed? Limited 1 [X] Yes 2 [ ] No

24b. Were autopsy findings eveileble prior to completion of cause of deeth? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Menner of Deeth: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Dete of Injury (Month, Day Yeer)
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred

28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the ceuse(s) end menner es steted. 2 [X] **Medical Examiner:** On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: Stephen S. Radentz MD
29c. License number: O.C.M.E.
29d. Dete signed (Month, Day, Yeer): May 7, 1997

30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print): Stephen S. Radentz, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Day, Yeer): MAY 21 1997
32. Registrar's Signature: Janice Morrison-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17104

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Lest): Honorata Alasca

2. Dete of Deeth — Month: May Day: 20, Yeer: 1997

3. Time of Death: 8:00 PM

4e. Fecility Name (If not institution, give street and number): Suburban Hospital

4b. City, Town, or Location of Deeth: Bethesda

4c. County of Deeth: Montgomery

Funeral Director

5. Social Security Number: 219-78-5752

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. lest birthday): 81 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Yeer): January 11, 1916

9. Birthplace (Stete or Foreign Country): Philippines

Usuel Residence of Decedent

10e. Stete: Maryland

10b. County: Montgomery

10c. City, Town or Location: Chevy Chase

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 3202 Farmington Drive

10f. Zip Code: 20815

10g. Citizen of Whet Country?: United States

11. Meritel Status: 1☒ Never Merried 2☐ Merried 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Yeer or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Bleck, White, etc. Specify: Asian Filipino

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondary (0-12): 4 — College (1-4or 5+):

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Child Care Provider

16b. Kind of Business/Industry: Private Homes

17. Fether's Neme (First, Middle, Lest): Juan Alasca

18. Mother's Neme (First, Middle, Meiden Surname): Juana (unavailable)

19e. Informent's Name/Reletionship (Type, Print): Celerina R. Manlapaz

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 3202 Farmington Drive, Chevy Chase, Maryland 20815

20a. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Chesapeake Crematory

Dete: 5-22-97

20c. Location - City or Town, State: Beltsville, Maryland

21. Signeture of Funerel Service Licensee: Carol a Dela

22. Neme and Address of Facility: Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 20910

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

JW

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Pert1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse *on* eech line.

Approximete Intervel Between Onset end Deeth

Immediate Ceuse (Final disease or condition resulting in deeth)

e. Congestive Heart Failure — Approximete Intervel: one week

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest

b. Renal Failure

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Pert II. **Other significent conditions** contributing to deeth but not resulting in the underlying cause given in Pert I.

Non insulin Dependent Diabetes Mellitus with Hypoglycemia

Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings aveileble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medicel exeminer? 1☐ Yes 2☒ No

26. Piece of Deeth (Check only one): Hospital: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Nelurel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer):

28b. Time of Injury: M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred:

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify):

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete):

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner**: On the beslis of examination and/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: Wilkinson J. Ninala

29c. License number: D45285

29d. Dete signed (Month, Dey, Yeer): May 21, 1997

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): Wilkinson J. Ninala, M.D., 18111 Prince Phillip Drive, Suite 212, Olney, MD 20832

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the buriel-transit

Division of Vital Records, P.O. Box 68760,

6

State Registrar

31. Dete filed (Month, Dey, Yeer): MAY 23 1997

32. Registrar's Signature: Julia Davidson-Randall

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17105

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lloyd R. Arnold

2. Date of Death Month: MAY Day: 15 Year: 1997

3. Time of Death: 0940 A

4e. Facility Name (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPTIAL

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 210-09-9645

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 80 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 6, 1916

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 513 Park Road

10f. Zip Code: 20850

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Electrician

16b. Kind of Business/Industry: Self Employed

17. Father's Name (First, Middle, Last): William Arnold

18. Mother's Name (First, Middle, Maiden Surname): Lillian not available

19a. Informant's Name/Relationship (Type, Print): Marjorie G. Arnold/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7407 Lake Katrine Terrace, Gaithersburg, MD 20879

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Muddy Creek Cemetery Date: May 21, 1997

20c. Location - City or Town, State: Washington, Pennsylvania

21. Signature of Funeral Service Licensee: Barbara J. McMullen Lawrence M00831

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Acute Myocardial Infarction	Minutes
Due to (or as a consequence of): b.	Coronary Vascular disease	years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last: Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Gary W. Langston MD

29c. License number: L17947

29d. Date signed (Month, Day, Year): May 15, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gary W. Langston 9901 Medical Center Drive, Rockville, Md.

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

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Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97-7106

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joseph Axelrod

2. Date of Death: Month May, Day 22, Year 1997

3. Time of Death: 11:00am

4a. Facility Name (If not institution, give street and number): Montgomery General Hospital

4b. City, Town, or Location of Death: Olney

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 067-03-7715

6. Sex: 1☒M 2☐F

7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): Dec. 13, 1912

9. Birthplace (State or Foreign Country): Romania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 3311 Solomons Court

10f. Zip Code: 20906

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Dress Pattern Maker

16b. Kind of Business/Industry: Dress Company

17. Father's Name (First, Middle, Last): Yaakov Axelrod

18. Mother's Name (First, Middle, Maiden Surname): Jenny Schwartz

19a. Informant's Name/Relationship (Type, Print): Ray Axelrod/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3311 Solomons Court Silver Spring, MD 20906

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Lebanon Cemetery

Date: 5/23/97

20c. Location - City or Town, State: Adelphi

21. Signature of Funeral Service Licensee: Paul Lipoff

22. Name and Address of Facility: Ives-Pearson Funeral Homes 472 N. Washington St. Falls Church, VA 22046

To Be Completed by Funeral Director

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

AXELROD, JOSEPH

CP

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Ischemic cardiomyopathy

Due to (or as a consequence of): Myocardial infarction

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I: Aortic stenosis, atrial fibrillation pneumonia, dementia

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Roger F. Leonard MD

29c. License number: 28791

29d. Date signed (Month, Day, Year): May 22, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Roger Leonard MD, 3801 International Dr. Silver Spring MD 20906

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): MAY 23 1997

32. Registrar's Signature: Julia Davidson-Randall

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17107

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): ROTI AZARYAD

2. Date of Deeth: Month MAY Dey 17 Yeer 97

3. Time of Death: 1:26 PM

4a. Facility Neme (If not institution, give street and number): SUBURBAN HOSPITAL

4b. City, Town, or Location of Deeth: BETHESDA

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 212-27-6391

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 90 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Day, Year): 01-01-1907

9. Birthplece (State or Foreign Country): REP. OF GEORGIA

Usual Residence of Decedent

10e. Stete: MD

10b. County: MONTGOMERY

10c. City, Town or Location: CHEVY CHASE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 4601 N. PARK AVE. APT# 712

10f. Zip Code: 20815

10g. Citizen of Whet Country?: IRAN

11. Maritel Stetus: 1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☐ No Specify:

14. Race - American Indien, Bleck, White, etc. Specify: WHITE

15. Decedent's Educetion (Specify only highest grade completed): Elementery/Secondary (0-12): 10 / College (1-4or 5+):

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Father's Neme (First, Middle, Last): ABRAHAM KATZOSHVILI

18. Mother's Neme (First, Middle, Maiden Surname): MIRIAM MOCHASHVILY

19e. Informent's Neme/Relationship (Type, Print): TONI AZARYAD

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4601 N. PARK AVE. CHEVY CHASE, MD. 20815

20a. Method of Disposition: 1☐ Burial 2☐ Cremetion 3☒ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Plece of Disposition (Name of cemetery, crematory or other place): ARNAVUTKOY MEZARI

Dete: 05/21/97

20c. Location - City or Town, Stete: ISTANBUL, TURKEY

21. Signeture of Funeral Service Licensee: [signature]

22. Neme end Address of Feclity: IVES-PEARSON FUNERAL HOMES ARLINGTON, VA 22201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications, thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on eech line.

Approximete Intervel Between Onset end Deeth

Immediete Ceuse (Final diseese or condition resulting in deeth): a. acute Intracerebral Bleeding — 9 mo.

Due to (or es a consequence of):

Sequentielly list conditions, if eny, leeding to immediete ceuse. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in deeth) Lest:

b. Due to (or es e consequence of):

c. Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveileble prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes cese referred to medicel examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospital: 1☐ Inpetient 2☒ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete end place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier: [signature] MD

29c. License number: D08546

29d. Date signed (Month, Day, Year): may 17 1997

30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): John Tamber 8218 WISCONSIN AVE BETHESDA MD

State Registrar

31. Dete filed (Month, Day, Year): MAY 19 1997

32. Registrer's Signeture: Julia Davidson-Kendall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17108

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Carrie V. Anderson

2. Data of Death Month: May Day: 18 Year: 1997

3. Time of Death: 1510

4a. Facility Name *(If not institution, give street and number)*: PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 212-10-2650

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 84 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: Feb.22,1913

9. Birthplace *(State or Foreign Country)*: VA.

Usual Rasidance of Dacadant

10a. State: Md.

10b. County: Wicomico

10c. City, Town or Location: Mardela Springs

10d. Insida City Limits: 1☒ Yas 2☐ No

10e. Street and Number: 206 Church St.

10f. Zip Coda: 21837

10g. Citizan of Whet Country?: USA

11. Maritel Status: 1☐ Never Married 2☐ Marriad 3☒ Widowed 4☐ Divorced

12. Was Dacadant Evar in U.S. Armad Forces? 1☐ Yas 2☒ No If Yas, Giva Year or Datas:

13. Was Decedent of Hispenic Origin? (Spacify Yes or No- If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 1☐ Yas 2☒ No *Specify:*

14. Race - Amarican Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grada completed)*: Elementary/Secondary (0-12): 5 / Collega (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT use retired)*: Seamstress

16b. Kind of Businass/Industry: Garment Co.

17. Fathar's Nama *(First, Middla, Lest)*: Ollie B. Parks

18. Mothar's Name *(First, Middla, Maidan Surnama)*: Maggie Wheatley Parks

19a. Informant's Name/Ralationship *(Type, Print)*: Pamela Wilson, Daughter

19b. Mailing Address *(Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 612 Hickory Lane, Seaford, De. 19973

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from State 4☐ Donation 5☐ Other *(Spacify)*

20b. Place of Disposition *(Nama of cematery, cramatory or othar place)*: Mardela Springs Cem.

Data: 5-22

20c. Location - City or Town, State: Mardela Springs, Md.

21. Signatura of Funeral Sarvice Licansaa: William M. Hoth

22. Nama and Address of Facility: Short Funeral Home, Inc. 13 E. Grove St. Delmar, De. 19940

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Entar tha disaase, or complications thet caused the death. Do not anter the moda of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one ceusa on aach line.

Approximete Intarval Batween Onsat end Deeth

Immediata Cause (Final disaase or condition resulting in daath)

a. Congestive heart failure — 4YRS

Dua to (or as a consaquance of):

Sequentially list conditions, if any, leading to immadiate causa. Enter Underlying Causa (Disaasa or injury that initiated events resulting in daath) Last

b. Ischemic cardiomyopathy — 4YRS

Dua to (or as a consaquance of):

c. Coronary artery disease — 4YRS

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.

Pneumonitis

23b. **Did tobacco use contribute to the cause of death?** 1☐ **Yes** 2☐ **No** 3☐ **Probably** 4☑ **Unknown**

24a. Was an autopsy performed? 1☐ Yas 2☑ No

24b. Wara autopsy findings available prior to complation of causa of daath? 1☐ Yas 2☐ No

25. Was cese refarred to medical examiner? 1☐ Yas 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatiant 2☐ ER/Outpatient 3☐ DOA Othar: 4☐ Nursing Home 5☐ Residance 6☐ Othar *(Specify)*

27. Manner of Death: 1☑ Naturel 2☐ Accidant 3☐ Suicide 4☐ Homicida 5☐ Pending Investigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Place of Injury - At homa, farm, straat, factory, office building, etc. *(Spacify)*

28f. Location *(Straat and Number or Rural Routa Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Carrie Anderson

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29e. Certifiar *(Check only one)*: 1☑ **Certifying Physician:** To tha best of my knowledge, deeth occurred at the tima, date and place, end due to tha causa(s) and manner as steted. 2☐ **Medical Examiner:** On tha basis of examination and/or investigetion, in my opinion, deeth occurred at tha tima, date and piece, and due to tha ceuse(s) and mannar stated.

29b. Signatura and title of certifier: Steph Pan MD

29c. Licansa numbar: D41721

29d. Data signed *(Month, Day, Year)*: 5/18/97

30. Nama and eddress of person who completed causa of daath (Item 23a) (Type, Print): STEPHAN PAVLOS MD 560 RIVERSIDE DR SUITE B101 SALISBURY MD 21804

State Registrar

31. Data filed *(Month, Day, Year)*: MAY 20 1997

32. Registrar's Signatura: John Davidson Rudell

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17109

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Levina Mae ARK
2. Date of Death Month Day Year: May 23, 1997
3. Time of Death: 2:45 PM
4a. Facility Name *(If not institution, give street and number)*: Dennett Road Manor Nursing Home
4b. City, Town, or Location of Death: Oakland
4c. County of Death: Garrett

Funeral Director

5. Social Security Number: 212-38-6256
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 99 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Apr. 22, 1898
9. Birthplace *(State or Foreign Country)*: West Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: Garrett
10c. City, Town or Location: Oakland
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: Fingerboard Road
10f. Zip Code: 21550
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates: X
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife
16b. Kind of Business/Industry: Home

17. Father's Name *(First, Middle, Last)*: Amos ----- Hemrick
18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Olive Messenger

19a. Informant's Name/Relationship *(Type, Print)*: Mildred A. Stemple/Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: HC82, Box 13, Aurora, West Virginia 26705

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Lantz Ridge Cemetery
Date: 5/26/97
20c. Location - City or Town, State: Amboy, West VA.

21. Signature of Funeral Service Licensee: Bradley N. Stewart
22. Name and Address of Facility: Stewart Funeral Home, 32 S. Second St., Oakland, MD 21550

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. dehydration — 1 week
Due to (or as a consequence of):
b. alzheimer's disease — 5 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: anemia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in *my* opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Walter K. Naumann M.D.
29c. License number: D25759
29d. Date signed *(Month, Day, Year)*: May 24, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Walter K. Naumann, M.D., 106 Cemetery Road, Accident MD 21520-0247

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 27 1997
32. Registrar's Signature: Jeri Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17110

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BLANCHE MARIE ALLEN

2. Date of Death: Month MAY Day 17, Year 1997

3. Time of Death: 3:15 A.M.

4a. Facility Name (If not institution, give street and number): MERIDIAN NURSING HOME HAMMANDS LANE

4b. City, Town, or Location of Death: BROOKLYN PARK

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 217-16-3323

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Yaar: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): 05-22-1906

9. Birthplace (State or Foreign Country): KENTUCKY

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: GLEN BURNIE

10d. Insida City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 315 5TH AVENUE, S.E.

10f. Zip Code: 21061

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yas, Giva Yeer or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 6 | College (1-4or 5+): N/A

18a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): SALESPERSON

16b. Kind of Business/Industry: CEMETERY

17. Fether's Neme (First, Middle, Last): JOHN GALLOWAY

18. Mother's Neme (First, Middle, Maiden Sumeme): ERIE NANCE

19e. Informent's Neme/Reletionship (Type, Print): HAROLD E. ALLEN (SON)

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 1682 KIRKWOOD ROAD, BALTIMORE, MD. 21207

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Steta 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): GLEN HAVEN MEMORIAL PARK

Data: 5/21/97

20c. Location - City or Town, Stete: GLEN BURNIE, MD.

21. Signature of Fdheral Service Licensee ▶

22. Neme end Address of Facility: SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part. Enter the disease, or complications thet caused the death. Do not enter tha moda of dying, such as cardiac or raspiratory errest, shock, or heart failure. List only one cause on eech line.

Approximeta Interval Between Onset and Death

Immediete Ceuse (Finel diseese or condition resulting in death): e. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — 5 YEARS

Due to (or as e consequenca of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Last:

b. Due to (or es e consequence of):

c. Due to (or es a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying causa givan in Part I.: MYELODYSPLASTIC SYNDROME

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yas 2☒ No

28. Place of Deeth (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Othar (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stata)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) end menner as stated. 2☐ **Medical Examiner:** On the besis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, dete end pieca, and dua to the cause(s) end menner stated.

29b. Signetura and title of certifier ▶ Attending

29c. Licensa number: D21776

29d. Data signed (Month, Dey, Year): MAY 20 1997

30. Nema and address of person who completed cause of deeth (Item 23e) (Type, Print): SURYA MONDRA MD 8109 RITCHIE HWY PASADENA MD 21122

State Registrar

31. Date filed (Month, Day, Year): MAY 22 1997

32. Registrer's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17111

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Elizabeth P. Armstrong
2. Dete of Death: Month MAY Dey 12 Yeer 1997
3. Time of Deeth: 1030
4a. Feclity Neme (If not institution, give street end number): PENINSULA REGIONAL MEDICAL CENTER
4b. City, Town, or Location of Deeth: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 219-05-0913
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. lest birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Yeer): 7-27-22
9. Birthplace (Stete or Foreign Country): MD.

Usuel Residence of Decedent

10e. Stete: MD
10b. County: Worcester
10c. City, Town or Location: Pocomoke
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 1210 Market Street
10f. Zip Code: 21851
10g. Citizen of Whet Country?: U.S.A.
11. Meritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - Americen Indien, Bleck, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th grade | College (1-4or 5+):
16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: Poultry
17. Fether's Neme (First, Middle, Last): Moses F. Smith
18. Mother's Neme (First, Middle, Meiden Surneme): Myrtle Beckett
19e. Informent's Neme/Reletionship (Type, Print): Edward V. James III,
19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code): P. O. Box 452 Pocomoke Md, 21851
20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other place): Halls Hill Cemetary
Dete: 5-17-97
20c. Locetion - City or Town, State: Pocomoke md,
21. Signeture of Funerel Service Licensee:
22. Neme and Address of Feclity: Bennie Smith Funeral Home P. O. Box 691 Dover De. 19903

Physician /Medical Examiner

23e. Pert 1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heert feilure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediete Ceuse (Finel disease or condition resulting in deeth): e. Metastatic Colon Cancer — 1½ yrs

Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in deeth) Last:
b.
Due to (or es e consequence of):
c.
Due to (or es a consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Locetion (Street end Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of exemineticn end/or investigation, in my opinion, death occurred et the time, dete and plece, end due to the cause(s) end manner stated.

29b. Signeture and title of certifier: , MD
29c. License number: D 26278
29d. Date signed (Month, Dey, Yeer): 5-13-97

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): David Cowall, MD 145 E Carroll St. Salisbury, MD 21801

State Registrar

31. Dete filed (Month, Dey, Yeer): MAY 16 1997
32. Registrer's Signeture: John Howdon Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

219-05-0913

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

ELIZABETH F. ARMSTRONG

AMENDED #9, #10c, #10d, 5/21/97 B.P., WORCESTER CO.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17112

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CHARLES AUSMUS

2. Date of Death Month Day Year: May 16 1997

3. Time of Death: 1325

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 116-10-5482

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): January 3, 1921

9. Birthplace (State or Foreign Country): NEW YORK / Pennsylvania

Usual Residence of Decedent

10a. State: Md.

10b. County: Worcester

10c. City, Town or Location: ~~Berlin~~ (OCEAN CITY)

10d. Inside City Limits: 1☒ Yes 2☒ No

10e. Street and Number: 167-B Jamestown Road

10f. Zip Code: 21842

10g. Citizen of What Country: US

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Certified Public Accountant

16b. Kind of Business/Industry: Self Employed

17. Father's Name (First, Middle, Last): Ellis Ausmus

18. Mother's Name (First, Middle, Maiden Surname): Juanita Gallegos

19a. Informant's Name/Relationship (Type, Print): Norma Ausmus)wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 167-B Jamestown Rd., Ocean City, Md. 21842

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Maryland Vet. Cemetery

Date: 5-20-97

20c. Location - City or Town, State: Hurlock, Md.

21. Signature of Funeral Service Licensee: [signature] 11005184

22. Name and Address of Facility: The Burbage Funeral Home 108 William St., Berlin, Md. 21811

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Carcinoma Urinary Bladder 4 yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Metastatic ca to Spinal cord

ASHD, Diabetes Mellitus II

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D.

29c. License number: 27670

29d. Date signed (Month, Day, Year): 5/17/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): M.L. M. Evangelista 105 Pine Ridge Rd #4 Salisbury, MD 21801

State Registrar

31. Date filed (Month, Day, Year): MAY 19 1997

32. Registrar's Signature: [signature] Rodell

DHMH 16 Rev 6/95

Charles Ausmus
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17113

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ELDRIDGE L. ARMACOST

2. Date of Death (Month, Day, Year): MAY 12, 1997

3. Time of Death: 11 A.M.

4a. Facility Name (If not institution, give street and number): LONG VIEW NURSING HOME

4b. City, Town, or Location of Death: MANCHESTER

4c. County of Death: CARROLL

Funeral Director

5. Social Security Number: 213-16-9500

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): OCT 14,1920

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: CARROLL

10c. City, Town or Location: HAMPSTEAD

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 1201 NORTH CARROLL STREET

10f. Zip Code: 21074

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Navar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedant Evar in U.S. Armed Forcas? 1 [ ] Yes 2 [X] No If Yes, Give Yaar or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): AGENT

16b. Kind of Business/Industry: NATIONWIDE INSURANCE

17. Father's Name (First, Middle, Last): RAYMOND F. ARMACOST, SR

18. Mother's Neme (First, Middle, Meiden Surneme): RACHAEL COLE

19a. Informant's Name/Relationship (Type, Print): NORA LEE ARMACOST

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code): 1201 NORTH CARROLL ST, HAMPSTEAD, MD 21074

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Ramoval from State 4 [ ] Donation 5 [ ] Other (Spacify)

20b. Place of Disposition (Nama of cemetary, crematory or other place): GRACE CEMETERY

Data: 5/16

20c. Location - City or Town, Stata: HAMPSTEAD, MD

21. Signature of Funeral Service Licensee: ▶ Steven W Eline

22. Name and Address of Facility: ELINE FUNERAL HOME 934 SOUTH MAIN ST, HAMPSTEAD, MD 21074

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disaasa, or complications that caused the daath. Do not anter the mode of dying, such as cerdiac or raspiratory arrest, shock, or heart feilure. List only one cause on each line.

Approximata Interval Between Onset and Death

Immediate Ceuse (Final disaase or condition resulting in death): a. Shock Bowl Syndrome — 6 mth

Due to (or as a consequence ol): b. Superior Mesentic Artery Syndrome — 6 mth

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last

Dua to (or as a consequence of): c. Peripheral Vascular Disease — Years

Dua to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. Stroke

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy lindings aveilable prior to completion of cause ol death? 1 [ ] Yes 2 [X] No

25. Wes case relerred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, straat, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2 [ ] **Medical Examiner:** On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signatura and title of certifier: ▶ MD

29c. License number: 33165

29d. Data signed (Month, Day, Year): 5/13/97

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print): Steven Shaffer 2111 Hanover Pike Hanpstead MD 21074

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): MAY 16 1997

32. Registrar's Signature: Jobi Swatson-Randall

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17114

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: LILLIAN B. ADAMS

2. Date of Death Month: MAY Day: 18 Year: 97

3. Time of Death: 0505 AM

4a. Facility Name *(If not institution, give street and number)*: Howard County General Hospital

4b. City, Town, or Location of Death: Columbia

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 212-74-3319

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 98 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sept. 14, 1897

9. Birthplace *(State or Foreign Country)*: Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore County

10c. City, Town or Location: Lutherville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 32 Croftley Road

10f. Zip Code: 21093

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: At Home

17. Father's Name *(First, Middle, Last)*: Lee Benson

18. Mother's Name *(First, Middle, Maiden Surname)*: Elizabeth Hennegen

19a. Informant's Name/Relationship *(Type, Print)*: Robert L Hart (Nephew

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 210 Brezy Acres Lane Queenstown, Maryland 21658

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St. Annes Cemetery

Date: 05/21/97

20c. Location - City or Town, State: Annapolis

21. Signature of Funeral Service Licensee: Robert L. Wilson

22. Name and Address of Facility: John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, Maryland 21401

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. CEREBRAL VASCULAR ACCIDENT — RECURRENT

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. ATHEROSCLEROSIS — YEARS

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part ii. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part i.

- DEMENTIA
- OSTEOPOROSIS
- GLAUCOMA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jay Ellis Jacobs

29c. License number: D2F210

29d. Date signed *(Month, Day, Year)*: MAY 1997

30. Name and address of person who completed cause of death (item 23e) (Type, Print): JERRY JACOBS ELLICOTT CITY MD 21043

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 20 1997

32. Registrar's Signature: Gena Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17115

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CATHERINE DADDS ANTHONY

2. Data of Death Month Day Year: May 4, 1997

3. Time of Death: 10:50PM

4a. Facility Name *(If not institution, give street and number)*: 121 Charity Lane

4b. City, Town, or Location of Death: Queenstown

4c. County of Death: Queen Anne's

Funeral Director

5. Social Security Number: 215-74-7309

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 23, 1908

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: Queen Anne's

10c. City, Town or Location: Queenstown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 121 Charity Lane

10f. Zip Code: 21658

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Rece - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 7 / College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry:

17. Father's Name *(First, Middle, Last)*: James Madison Dadds

18. Mother's Neme *(First, Middle, Melden Surname)*: Carrie M. Pinder

19a. Informent's Neme/Relationship *(Type, Print)*: Vince Anthony (Son)

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P.O. Box 81, Queenstown, Md. 21658

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetary, cremetory or other piece)*: Chesterfield Cemetery — Date: May 9, 1997

20c. Location - City or Town, State: Centreville, Md.

21. Signature of Funeral Service Licensee: Chad M. Helfenbein

22. Neme end Addrass of Facility: Fellows, Helfenbein & Newnam Funeral HOme, P.A. 106 Shamrock Rd., Chester, Md. 21619

Physician /Medical Examiner

23a. Pert1. Enfar the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac of respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximate Intervel Between Onsef and Death

Immediate Cause (Finel diseese or condition resulting in death) e. Cachexia — 2 mo

Due to (or es a consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseesa or injury thet Initieted events resulting in deeth) Last

b. Pernicious Anemia — Remote

Due to (or es e consequence of):

c.

Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yas 2☐ No

24b. Were autopsy findings eveileble prior to complation of causa of deeth? 1☐ Yas 2☐ No

25. Wes case referred to medical exeminar? 1☐ Yas 2☒ No

26. Piace of Deeth *(Check only one)*: Hospitel: 1☐ Inpatlanf 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Mennar of Deeth: 1☒ Neturel 2☐ Accidant 3☐ Sulcide 4☐ Homicida 5☐ Panding investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Tima of Injury

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At homa, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check one)*: 1☒ **Certifying Phyaician:** To the best of my knowledge, deeth occurred et the time, dete and piece, end due to the ceuse(s) end manner as stated. 2☐ **Medical Examinar:** On the basis of exemination and/or investigetion, in my opinion, deeth occurred et the time, dete end piace, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: Ralph Libby

29c. Licensa number: D05754

29d. Dete signed *(Month, Day, Year)*: 5-7-97

30. Neme end eddress of person who completed causa of Neeth (item 23a) (Type, Print): Ralph Libby, M.D.; 204 Medical Center Rd.; Grasonville, Md. 21638

State Registrar

31. Dete filed *(Month, Dey, Year)*: MAY 07 1997

32. Registrer's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17116

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joseph E. Ahern

2. Date of Death: Month May Day 19 Year 1997

3. Time of Death: 2:51 PM

4a. Facility Name (If not institution, give street and number): Doctors' Community Hospital

4b. City, Town, or Location of Death: Lanham

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 216 34 4055

6. Sex: 1☐M 2☐F XX

7. Age (In yrs. last birthday): 59 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 19, 1938

9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: New Carrollton

10d. Inside City Limits: 1☐Yes 2☐No XX

10e. Street and Number: 6105 84th Ave.

10f. Zip Code: 20784

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☒ Married XX 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No XX Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondary (0-12):

College (1-4or 5+): 1

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Computer Specialist

16b. Kind of Business/Industry: U.S.N. Department

17. Father's Name (First, Middle, Last): Joseph E. Ahern Sr.

18. Mother's Name (First, Middle, Maiden Surname): Gertrude M. Reynolds

19a. Informant's Name/Relationship (Type, Print): Paulette Imler-Ahern Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6105 84th Ave. New Carrollton Maryland 20784

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Restlawn Memorial Gardens

Date: 5/23/97

20c. Location - City or Town, State: LaVale Maryland

21. Signature of Funeral Service Licensee: Robert E. Evans Jr.

22. Name and Address of Facility: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Md. 20715

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Chronic Heart Disease — 4 yrs

Due to (or as a consequence of):

b. Hypertension — 4 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last

Due to (or as a consequence of):

c. Hypercholesterolemia — 4 yrs

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Htn & MI x2

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No XX 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No XX

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☒ ER/Outpatient XX 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: James R. McClain

29c. License number: D30858

29d. Date signed (Month, Day, Year): May 20, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James Pollock, MD 14338 Chesterfield Road, Rockville, MD 20853

State Registrar

31. Date filed (Month, Day, Year): MAY 21 1997

32. Registrar's Signature: Julia Sheridan-Randall

DHMH 16 Rev 6/95

JOSEPH AHERN

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

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Division of Vital Records, P.O. Box 68760,

12

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17117

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: CARLONDO ALSTON

2. Dete of Deeth Month: 5 Day: 17 Year: 97

3. Time of Death: 843 AM

4a. Facility Name *(If not institution, give street and number)*: Heartland @ Hyattsville

4b. City, Town, or Location of Death: hyattsville, md

4c. County of Death: PG

Funeral Director

5. Social Security Number: 578920587

6. Sex: 1☐ M 2☐ F

7. Age *(In yrs. last birthday)*: 35 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Day, Year)*: Jan. 13, 1962

9. Birthplece *(State or Foreign Country)*: Wash. DC

Usual Residence of Decedent

10e. Stete

10b. County

10c. City, Town or Location: Washington, D.C.

10d. Inside City Limits: XX 1☐ Yes 2☐ No

10e. Street end Number: 2321 14th Place, S.E.

10f. Zip Code: 20020

10g. Citizen of Whet Country?: USA

11. Maritel Stetus: X 1☐ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No (X) If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No (XX) *Specify:*

14. Race - American Indien, Bleck, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondary (0-12): 11th; College (1-4or 5+):

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Food Service

16b. Kind of Business/Industry: St. Elizabeth

17. Fether's Neme *(First, Middle, Last)*: Carl Cross

18. Mother's Neme *(First, Middle, Maiden Surneme)*: Carolyn Alston

19e. Intorment's Name/Reletionship *(Type, Print)*: Carolyn Saunders/mother

19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, State, Zip Code)*: 2321 14th Place, SE Wash., DC 20020

20e. Method of Disposition: XX Buriel 2☐ Cremetion 3☐ Removel trom Stete 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Lincoln Memorial Cemetery

Dete: 05/22/97

20c. Location - City or Town, Stete: Suitland, Md.

21. Signeture of Funerel Service Licensee: Phillip Bell

22. Neme end Address of Feciility: Robert G. Mason Funeral Home 1661 Good Hope Rd., SE Wash., DC 20002

Physician /Medical Examiner

23e. Pert1. Enter the diseese, or complicetions thet caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart teilure. List only one ceuse on each line.

Approximete Intervel Between Onset end Deeth

Immediete Ceuse (Finel diseese or condition resulting in deeth)

e. CARDIO RESPIRATORY FAILURE

Due to (or es e consequence of):

b. AIDS

Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in deeth) Lest

Due to (or es e consequence of):

c. Seizure Disorder

Due to (or es e consequence of):

d. Dementia

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No (X) 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No (X)

24b. Were autopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? (X) 1☐ Yes 2☐ No

26. Place of Deeth *(Check only one)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: (X) 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: (X) 1☐ Neturel 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28e. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

26f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: (X) 1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) and menner as steted. 2☐ **Medical Examiner:** On the basis ot examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete end piece, and due to the cause(s) and menner stated.

29b. Signeture end title of certifier: MD

29c. License number: D42019

29d. Dete signed *(Month, Dey, Year)*: 19TH MAY 1997

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): LYRAN GOODHOPE 7350 VAN DUSEN Rd LANHAM MD 20706

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 22 1997

32. Registrar's Signature: John Strickland Kimball

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17118

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): FRANK - ANNECILLO

2. Dete of Deeth — Month: MAY; Dey: 05; Yeer: 97

3. Time of Death: 01:23AM

4a. Facility Neme (If not institution, giva street and number): St. Mary's Hospital

4b. City, Town, or Location of Deeth: Leonardtown

4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 172-10-3490

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 81 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Day, Yeer): Oct 22, 1915

9. Birthplece (State or Foraign Country): Pennsylvania

Usuel Residence of Decedent

10a. Stete: Maryland

10b. County: Prince Georges

10c. City, Town or Location: District Heights

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 6711 Gateway Blvd

10f. Zip Code: 20747

10g. Citizen of Whet Country?: U.S.A.

11. Meritel Status: 1☐ Never Merried 2☒ Merried 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12th grade; College (1-4or 5+):

16a. Decedent's Usuel Occupetion (Giva kind of work done during most of working life. DO NOT usa retired): Master Sgt.

16b. Kind of Business/Industry: U.S. Airforce

17. Fether's Neme (First, Middle, Last): Louis Iannuccelli

18. Mother's Name (First, Middle, Maidan Surnama): Victoria D'Ambrosia

19a. Interment's Neme/Reletionship (Type, Print): Joyce Annecillo/Spouse

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code): 6711 Gateway Blvd., District Heights, MD 20747

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Name of cematary, cramatory or other piece): Metropolitan Crematory

Dete: 5/6/97

20c. Location - City or Town, Stete: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Michael K. Gardiner

22. Neme end Address of Facility: Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650

Physician /Medical Examiner

23e. Part I. Enter the disease, or complications thet caused the deeth. Do not enter the mode ot dying, such es cardiec or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediete Cause (Finel diseese or condition resulting in death): e. MRSA Sepsis — Few Days.

Due to (or es a consequence of):

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in deeth) Last:

b. Pan Cytopenia

Due to (or as e consequence ot):

c. Sidroblastic Myeloblastic Syndrome — Several months.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Renal failure, CHF,

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Piece of Deeth (Check only one): Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of injury - At home, tarm, street, tactory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the bast of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner as stated. 2☐ **Medical Examiner:** On the basis ot examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, and due to the cause(s) end menner steted.

29b. Signeture and title of certifier: Zahir Yousaf

29c. License number: D27189

29d. Dete signed (Month, Day, Year): 5/5/97

30. Neme and eddress ot person who completed cause ot deeth (item 23a) (Type, Print): Zahir Yousaf, M.D. Leonardtown, Maryland 20650

State Registrar

31. Dete filed (Month, Day, Year): MAY 06 1997

32. Registrer's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

97 17119

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Gretta B. Alexander. (Gretta Bartels Alexander)				2. DATE OF DEATH: MONTH 5 DAY 21 YEAR 97	3. TIME OF DEATH: 640 P M
4. SOCIAL SECURITY NUMBER: 213-74-1136	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 94 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): November 30,	8. BIRTHPLACE (State or Foreign Country): 1902 Ohio
9a. FACILITY NAME (If not institution, give street and number): Chestertown Nursing & Rehabilitation Center			9b. CITY, TOWN OR LOCATION OF DEATH: Chestertown		9c. COUNTY OF DEATH: Kent

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Kent	10c. CITY, TOWN OR LOCATION: Chestertown	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 5611 Langford Bay Road		10f. ZIP CODE: 21620	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Domestic/Own Home	
17. FATHER'S NAME (First, Middle, Last): Henry F. Bartels		18. MOTHER'S NAME (First, Middle, Maiden Surname): Elizabeth Maag	
19a. INFORMANT'S NAME (Type/Print): Audrey Ruth Sills/Niece	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11330 Green Cove Drive, Worton, Maryland 21678		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): May 22, 1997	20c. LOCATION — City or Town, State: Chesapeake Cremation Center, LLC Stevensville, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Kirk D. Keller	22. NAME AND ADDRESS OF FACILITY: Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardio Respiratory Arrest. DUE TO (OR AS A CONSEQUENCE OF):	2 hrs
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Coronary Artery Dz. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: CHF/s/p MI/ Dementia. /DM/ Peripheral Vascular Disease

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☒	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Neil Stoddard MD	29c. LICENSE NUMBER: D0050996	29d. DATE SIGNED (Month, Day, Year): ▶ 5/21/97

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Neil Stoddard MD 100 Brown St Chestertown MD.

31. DATE FILED (Month, Day, Year): MAY 23 '97	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randell

4

DHMH-16 Rev 1/89

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17120

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Richard Edgar Angleberger

2. Date of Deeth Month Dey Yeer: May 21, 1997

3. Time of Death: 8:04 PM

4e. Fecility Neme *(If not institution, give street end number)*: Frederick Memorial Hospital

4b. City, Town, or Location of Deeth: Frederick

4c. County of Deeth: Frederick

Funeral Director

5. Social Security Number: 214-10-1001

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 83 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Yeer)*: Jan. 3, 1914

9. Birthplece *(Stete or Foreign Country)*: Maryland

Usuel Residence of Decedent

10a. Stete: Maryland

10b. County: Frederick

10c. City, Town or Locelion: Frederick

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street end Number: 906 Cherokee Trail

10f. Zip Code: 21701

10g. Citizen of Whet Country?: U.S.A.

11. Maritel Status: 1 [ ] Never Merried 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Dates:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondery (0-12): 9 / College (1-4or 5+)

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Self Employed / Distributor

16b. Kind of Business/Industry: Bottled Water and Soda

17. Fether's Neme *(First, Middle, Last)*: Harry Edgar ANGLEBERGER

18. Mother's Name *(First, Middle, Meiden Surneme)*: Emma Virginia CRAMPTON

19e. Informent's Neme/Reletionship *(Type, Print)*: Mrs. Grace Angleberger, wife

19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 906 Cherokee Trail, Frederick, Maryland 21701

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Frederick Memorial Park, Date: May 24, 1997

20c. Location - City or Town, Stete: Frederick, Maryland

21. Signeture of Funeral Service Licensee: ▶ Richard E. Graf M00255

22. Neme end Address of Fecility: Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701

Physician /Medical Examiner

23a. Pert 1. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset end Deeth

Immediate Ceuse (Finel diseese or condition resulting in deeth): e. Coronary artery disease — 15 years

Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest: b. ____ Due to (or es e consequence of): c. ____ Due to (or es e consequence of): d. ____

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of deeth? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24e. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Plece of Deeth *(Check only one)*: Hospitel: 1 [ ] Inpetient 2 [X] ER/Outpetient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Menner of Deeth: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28e. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2 [ ] **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred el the time, date end place, end due to the ceuse(s) end menner stated.

29b. Signeture end titie of certifier: ▶ K. [signature]

29c. License number: D21648

29d. Dale signed *(Month, Dey, Yeer)*: 5/22/97

30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print): Kusay BARAKAT 310 w 9th street Frederick MD 21701

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: MAY 23 1997

32. Registrar's Signeture: John Davidson Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17121

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ARTHUR G. BENNETT
2. Date of Death Month: MAY Day: 2 Year: 1997
3. Time of Death: 6:35 PM
4a. Facility Name (If not institution, give street and number): ATLANTIC GENERAL HOSPITAL
4b. City, Town, or Location of Death: BERLIN
4c. County of Death: WORCESTER

Funeral Director

5. Social Security Number: 240-24-2278
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 74 Yrs. If Under 1 Year Months: Days: If Under 24 Hrs. Hours: Min.:
8. Date of Birth (Month, Day, Year): JAN 19, 1923
9. Birthplace (State or Foreign Country): NORTH CAROLINA

Usual Residence of Decedent

10a. State: DELAWARE
10b. County: SUSSEX
10c. City, Town or Location: FRANKFORD
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: Rt. 3 BOX 79 D
10f. Zip Code: 19945
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify: X
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Poultry Worker
16b. Kind of Business/Industry: Poultry

17. Father's Name (First, Middle, Last): Ollie Gallop
18. Mother's Name (First, Middle, Maiden Surname): Minnie Bennett

19a. Informant's Name/Relationship (Type, Print): Arthur Drummond / Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 3 BOX 79 D, Frankford, Delaware 19945

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): Zoar Golden Acres Cemetery
Date: 5/10
20c. Location - City or Town, State: Bishopville, Maryland

21. Signature of Funeral Service Licensee: Richard T. Watson
22. Name and Address of Facility: Watson Funeral Home, Inc. 211 Washington Street, Millsboro, DE 19966

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. cardiac arrest

Due to (or as a consequence of):
b. uncontrolled diabetes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. medication noncompliance

Due to (or as a consequence of):
d. alcoholism

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year): 05-02-97
28b. Time of Injury: M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: found unresponsive
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): HOME
28f. Location (Street and Number or Rural Route Number, City or Town, State): Frankfurt, DE

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier:
29c. License number: D44108
29d. Date signed (Month, Day, Year): 05-02-97

30. Name and address of person who completed cause of death (Item 23a) (Type/Print): DANIEL CARLIN MD / ACHER, Berlin, MD

State Registrar

31. Date filed (Month, Day, Year): MAY 07 1997
32. Registrar's Signature: Julia Davidson Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17122

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Vera F. Balesh

2. Data of Death — Month: May; Day: 17; Year: 1997

3. Time of Death: 7:48 A.M.

4a. Facility Name *(If not institution, give street and number)*: Shady Grove Adventist Nursing Center

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 127-14-3177

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 75 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: May 20, 1921

9. Birthplace *(State or Foreign Country)*: Canada

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 9701 Medical Center Drive

10f. Zip Code: 20850

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Telephone Operator

16b. Kind of Business/Industry: Telephone Company

17. Father's Name *(First, Middle, Last)*: John Gosse

18. Mother's Name *(First, Middle, Maiden Surname)*: Elizabeth Doyle

19a. Informant's Name/Relationship *(Type, Print)*: Adele L. Dillie/Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 13556 Smallwood Lane, Chantilly, Virginia 20151

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cemetery — Date: May 20, 1997

20c. Location - City or Town, State: Silver Spring, Maryland

21. Signature of Funeral Service Licensee: Ramp Funk M00198

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Septicemia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last

b. Myelofibrosis

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Rheumatoid Arthritis

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John E Kelly MD

29c. License number: D06349

29d. Date signed *(Month, Day, Year)*: May 17, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John E. Kelly, M.D. 2401 Research Blvd., Rockville, Maryland 20850

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 19 1997

32. Registrar's Signature: Julia Davidson-Randall

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

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DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 17123 AHN

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ISABELLE BERULIS

2. Date of Death Month: MAY Day: 20 Year: 97

3. Time of Death: 7:05 AM

4a. Facility Name *(If not institution, give street and number)*: Laurel Regional Hospital

4b. City, Town, or Location of Death: Laurel

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 189-05-7017

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 86 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec. 18, 1910

9. Birthplace *(State or Foreign Country)*: Illinois

Usual Residence of Decedent

10a. State: MD

10b. County: Howard

10c. City, Town or Location: Columbia

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 9354 Our Time Lane

10f. Zip Code: 21045

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Salesperson

16b. Kind of Business/Industry: Retail

17. Father's Name *(First, Middle, Last)*: Antonio Krasmesli

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Maloski

19a. Informant's Name/Relationship *(Type, Print)*: Jean M. Kranefeld

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9354 Our Time Lane, Columbia, MD 21045

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cemetery

Date: 5/22/97

20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: John L Chipola

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List *only* one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure — 7 days

Due to (or as a consequence of):

b. Arteriosclerotic Cardiovascular Disease — 3 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Pneumonia

Upper Gastrointestinal Bleeding

Senile Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D.

29c. License number: D 24721

29d. Date signed *(Month, Day, Year)*: 5/20/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SYED SADIQ, 14800 4th Street LAUREL, MD 20707

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 22 1997

32. Registrar's Signature: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17124

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mrs. Helen Bowles

2. Date of Death Month: MAY Day: 14 Year: 1997

3. Time of Death: 9:20 pm

4a. Facility Name *(If not institution, give street and number)*: Mariner Health of Greater Laurel

4b. City, Town, or Location of Death: Laurel

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 578-28-5281

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 87 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 28, 1910

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residance of Decedent

10a. State: Maryland

10b. County: Prince Georges

10c. City, Town or Location: Adelphi

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 8216 17th Ave.

10f. Zip Code: 20783

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Nevar Married 2☐ Marriad 3☒ Widowed 4☐ Divorced

12. Was Decedant Ever in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yas 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Home maker

16b. Kind of Business/Industry: Own Home

17. Father's Nama *(First, Middle, Last)*: Ira I. Leaman

18. Mother's Name *(First, Middle, Maidan Surname)*: Annie Stewart

19a. Informant's Name/Relationship *(Type, Print)*: Joyce Montgomery/niece

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1910 Appaloosa Way Owings, MD 20736-9717

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: George Washington cemetery

Date: May 16, 1997

20c. Location - City or Town, State: Adelphi, MD

21. Signature of Funaral Service Licensee: [signature]

22. Nama and Address of Facility: Takoma Funeral Home, Inc. 254 Carroll St. NW Washington, DC 20012

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter tha moda of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximala Interval Between Onset and Death

Immediate Causa (Final disease or condition resulting in death)

a. Urosepsis — 1 week

Due to (or as a consequence of):

Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Recurren Urinary Tract Infection

Due to (or as a consequence of):

c.

Due to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Senile dementia; Dehydration; Hypothyroidism

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Homa 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at tha time, date and place, and dua to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and titla of certifiar: [signature] ATTENDING

29c. Licansa number: D16200

29d. Data signed *(Month, Day, Year)*: MAY 15, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. N. M. MACHIRAN · 720-C MAIDEN CHOICE LA., CATONSVILLE, 21228

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 19 1997

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

2

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17125

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Brill

2. Date of Death Month Day Year: 5/16/97

3. Time of Death: 5:10 Am

4a. Facility Name (If not institution, give street and number): Springbrook Adventist Nursing Home

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 160-16-8859

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 7, 1920

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1102 Schindler Drive

10f. Zip Code: 20903

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nurse

18b. Kind of Business/Industry: Hospital

17. Father's Name (First, Middle, Last): Martin

18. Mother's Name (First, Middle, Maiden Surname): Edith Sites

19a. Informant's Name/Relationship (Type, Print): Susan Redshaw / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11100 Mears Creek Road, Lusby, Maryland 20657

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Maryland Venteran's Cem.

Date: 5/19/97

20c. Location - City or Town, State: Cheltenham, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Hines-Rinaldi Funeral Home
11800 New Hampshire Avenue
Silver Spring, Maryland 20904

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

GF

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Urosepsis.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Advanced Dementia, Hydrocephalus, Seizure Disorder, past Bilat Hip Prostheses, Asthma, Severe Thoracic Kyphosis.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☑ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 8☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D31001

29d. Date signed (Month, Day, Year): 5/16/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stuart J. Turkewitz, M.D.

7500 Greenway Ctr. Dr. #430
Greenbelt, Md. 20770

State Registrar

31. Date filed (Month, Day, Year): MAY 2 0 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17126

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jesse D. Brown
2. Date of Death: Month May, Day 20, Year 1997
3. Time of Death: 1:25 PM
4a. Facility Name (If not Institution, give street and number): Montgomery General
4b. City, Town, or Location of Death: Olney
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-09-5142
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Nov. 7, 1915
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 16309 Oak Hill Road
10f. Zip Code: 20905
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No. If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Steam Fitter
16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Mortimer D. Brown
18. Mother's Name (First, Middle, Maiden Surname): Rosa Elizabeth Strouse

19a. Informant's Name/Relationship (Type, Print): Margaret R. Brown / Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 16309 Oak Hill Road, Silver Spring, Maryland 20905

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Union Cemetery
Date: 5/23/97
20c. Location - City or Town, State: Burtonsville, Maryland

21. Signature of Funeral Service Licensee: Toni L. Holland
22. Name and Address of Facility: Hines-Rinaldi Funeral Home, 11800 New Hampshire Avenue, Silver Spring, Maryland 20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Arrhythmia - Ventricular Fibrillation	30 minutes
Due to (or as a consequence of):	b. Coronary Artery Disease	9 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Bennett Morrison MD
29c. License number: D 47682
29d. Date signed (Month, Day, Year): May 21, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Bennett Morrison 2901 Olney-Sandy Spring Rd Olney Maryland 20832

State Registrar

31. Date filed (Month, Day, Year): MAY 23 1997
32. Registrar's Signature: Gina Davidson-Randall

DHMH 16 Rev 6/95

To be completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To be completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17127

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Richard Alan Burroughs
2. Date of Death Month Day Year: May 21, 1997
3. Time of Death: 3:20 PM
4a. Facility Name *(If not institution, give street end number)*: 14571 Cutstone Way
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 213-14-2047
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June 20, 1919
9. Birthplace *(State or Foreign Country)*: Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 14571 Cutstone Way
10f. Zip Code: 20905
10g. Citizen of Whet Country?: USA

11. Maritel Stetus: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - Americen Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Vice President Metropolitan
16b. Kind of Business/Industry: Service

17. Father's Name *(First, Middle, Last)*: Henry Fowler Burroughs
18. Mother's Name *(First, Middle, Meiden Surneme)*: Grace L. De Corse

19a. Informant's Name/Relationship *(Type, Print)*: Mary B. Burroughs
19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 14571 Cutstone Way, Silver Spring, MD 20905

20a. Method of Disposition: 1 [X] Buriel 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Gate of Heaven Cemetery | Date: 5/24/97
20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: James E. Dooley
22. Name and Address of Feciility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mentel Hygiene.
Important: If item 27 is marked other than "naturel", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset end Deeth

Immediete Cause (Finel disease or condition resulting in deeth)
a. Metastatic Bladder Cancer — 1 Year

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were eutopsy findings available prior to completion of ceuse of deeth? 1 [ ] Yes 2 [X] No

25. Was cese referred to medicel examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and menner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.
29b. Signeture end title of certifier: Frederick P. Smith
29c. License number: D33293
29d. Date signed *(Month, Day, Year)*: May 22, 1997
30. Name end address of person who completed cause of death (Item 23a) (Type, Print): Frederick P. Smith, M.D., 5401 Western Ave., N.W. Washington, DC 20015

State Registrar

31. Dete filed *(Month, Day, Yeer)*: MAY 23 1997
32. Registrar's Signature: Julia Davidson-Randall

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

X

X X

X

D33293

.ave ni

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17128

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Donald E. Bruch

2. Data of Death Month: May Day: 20 Year: 1997

3. Time of Death: 9:00 P.M.

4a. Facility Name (If not institution, giva street and number): 9299 Colonial Mill Dr.

4b. City, Town, or Location of Death: Delmar

4c. County of Death: Wicomico

Funeral Director

5. Social Security Numbar: 204-12-8352

6. Sax: 1☒M 2☐F

7. Aga (In yrs. last birthday): 72 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): July 28, 1924

9. Birthplece (State or Foreign Country): Pa.

Usuel Residence of Decedent

10a. Stata: Md.

10b. County: Wicomico

10c. City, Town or Location: Delmar

10d. Insida City Limits: 1☐Yas 2☒No

10e. Street end Number: 9299 Colonial Mill Dr.

10f. Zip Code: 21875

10g. Citizan of Whet Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedant Ever in U.S. Armed Forcas? 1☒Yes 2☐No If Yes, Give Yaar or Datas: 1943-46

13. Wes Decedent of Hispenic Origin? (Specify Yas or No- if Yes, specify Cuban, Maxican, Puarto Rican, etc.) 1☐Yes 2☒No Specify:

14. Rece - Americen Indien, Black, White, atc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondery (0-12): 12

College (1-4or 5+):

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT usa retired): Electrical Engineer

16b. Kind of Business/Industry: Federal Government

17. Father's Name (First, Middle, Last): Guy Bruch

18. Mother's Name (First, Middle, Maiden Sumeme): Laura Hascher Bruch

19a. Informant's Neme/Reletionship (Type, Print): Shirley Bruch, Wife

19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9299 Colonial Mill Dr. Delmar, Md. 21875

20a. Method of Disposition: 1☐Buriel 2☒Cremetion 3☐Removal from Stata 4☐Donetion 5☐Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or othar piece): Cambridge Crematory

Data: 5-22-97

20c. Location - City or Town, Stata: Cambridge, Md.

21. Signeture of Funaral Sarvice Licensee: William M. Short

22. Nama end Address of Facility: Short Funeral Home, Inc. 13 E. Grove St. Delmar, De. 19940

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errast, shock, or heert feilure. List only one ceuse on aach line.

Approximate Interval Between Onset and Deeth

Immediete Cause (Finel disaesa or condition resulting in deeth): e. Respiratory failure — 4wks

Due to (or es a consequence of):

Sequentially list conditions, if eny, leeding to immediete ceuse. Enter Underlying Cause (Diseese or injury thet initieted events resulting in deeth) Last:

b. Non Small Cell Carcinoma of the Lung — 5 mos.

Due to (or es a consequance of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic Atrial Fibrillation

Brain Metastasis

23b. **Did tobacco use contributa to the cause of deeth?** 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Wes an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of ceuse of death? 1☐Yes 2☒No

25. Wes cesa referred to medical examiner? 1☐Yes 2☒No

26. Piece of Deeth (Check only one): Hospitel: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Homa 5☒Residence 6☐Othar (Specify)

27. Menner of Deeth: 1☒Natural 2☐Accident 3☐Suicida 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of injury (Month, Dey Year)

28b. Time of injury M

28c. injury at Work? 1☐Yas 2☐No

28d. Dascribe how injury occurred

28e. Piece of injury - At homa, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end plece, and due to the ceuse(s) end menner as steted. 2☐**Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and menner steted.

29b. Signeture end title of certifier: MD

29c. Licensa number: D24986

29d. Data signed (Month, Day, Year): 5/21/97

30. Neme and address of person who completed ceuse of deeth (Item 23a) (Type, Print): Robert J. Reilly MD 106 Milford St. Salisbury Md. 21804

State Registrar

31. Dete filed (Month, Day, Year): MAY 22 1997

32. Registrer's Signature: Julie Davidson Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17129

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: WANDA Lynn BISHOP
2. Data of Death Month: 05 Day: 16 Year: 97
3. Time of Death: 0712
4a. Facility Name *(If not institution, give street and number)*: PENINSULA REGIONAL MEDICAL CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 221-20-1814
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 64 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: 11 11 32
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: MD
10b. County: Wicomico
10c. City, Town or Location: Salisbury
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 206 Washington Street
10f. Zip Code: 21804
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 / College (1-4or 5+): --------
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife
16b. Kind of Business/Industry: Housewife

17. Father's Name *(First, Middle, Last)*: Peter Petrovich
18. Mother's Name *(First, Middle, Maiden Surname)*: Sophia Sturtz

19a. Informant's Name/Relationship *(Type, Print)*: Joseph I. Bishop, Sr./Spouse
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 206 Washington Street, Salisbury MD 21804

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Springhill Memory Gardens
Date: 5/19/97
20c. Location - City or Town, State: Hebron, MD

21. Signature of Funeral Service Licensee: W R Holloway Jr. CFSP
22. Name and Address of Facility: Holloway Funeral Home, P.A. 501 Snow Hill Road, Salisbury, MD 21804

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
PARKINSONS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John T Bulkeley D.M.E.
29c. License number: D03599
29d. Date signed *(Month, Day, Year)*: 5-16-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JOHN T. BULKELEY, M.D., 108 PINE BLUFF RD, SALISBURY MD 21801

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 19 1997
32. Registrar's Signature: Julie Davidson-Randall

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17130

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ELWOOD C. BAILEY

2. Date of Death: Month May Day 20 Year 1997

3. Time of Death: 1430

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 212-14-4406

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): NOV. 10-1919

9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD.

10b. County: WICOMICO

10c. City, Town or Location: PARSONSBURG

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 31579 ZION ROAD

10f. Zip Code: 21849

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TAX ASSESSOR

16b. Kind of Business/Industry: STATE of MARYLAND

17. Father's Name (First, Middle, Last): HENRY BAILEY

18. Mother's Name (First, Middle, Maiden Surname): LAURA OLIPHANT

19a. Informant's Name/Relationship (Type, Print): RUTH E. BAILEY

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 31579 ZION ROAD, PARSONSBURG, MARYLAND 21849

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MELSON'S CEMETERY

Date: 5/23/97

20c. Location - City or Town, State: DELMAR, MARYLAND

21. Signature of Funeral Service Licensee: Gerald L Bounds

22. Name and Address of Facility: BOUNDS FUNERAL HOME, 705 E. MAIN ST., SALISBURY, MD. 21804

To Be Completed by Funeral Director

Elwood Bailey

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac Dysrythmia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Congestive heart failure

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D34768

29d. Date signed (Month, Day, Year): 5/20/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JEFFREY Wieland 560 Riverside DR B101 Salisbury, Md

State Registrar

31. Date filed (Month, Day, Year): MAY 22 1997

32. Registrar's Signature: Julia Davidson Randall

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17131

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GEORGE ANDREW BOBICK, SR.

2. Date of Death (Month, Day, Year): MAY 18, 1997

3. Time of Death: 6:42 P.M.

4a. Facility Name (If not institution, give street and number): GARRETT COUNTY MEMORIAL HOSPITAL

4b. City, Town, or Location of Death: OAKLAND

4c. County of Death: GARRETT

Funeral Director

5. Social Security Number: 193-10-6741

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): MAY 2, 1915

9. Birthplace (State or Foreign Country): PENNSYLVANIA

Usual Residence of Decedent

10a. State: MD

10b. County: GARRETT

10c. City, Town or Location: McHENRY

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: BOX 881

10f. Zip Code: 21541

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): COAL MINER

16b. Kind of Business/Industry: COAL MINING

17. Father's Name (First, Middle, Last): JOHN BOBICK

18. Mother's Name (First, Middle, Maiden Surname): ELIZABETH BALOG

19a. Informant's Name/Relationship (Type, Print): GREGORY A. BOBICK, SR.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): BOX 881 McHENRY, MARYLAND 21541

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): CHURCH OF RESURECTION CEM

Date: 5/21

20c. Location - City or Town, State: CLYMER, PENNA.

21. Signature of Funeral Service Licensee: Robert M. Durst M00167

22. Name and Address of Facility: DURST FUNERAL HOME - P.O. BOX 243 OAKLAND, MD 21550

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	ischemic colitis	1.5 months
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b.	Peripheral vascular disease	30 years
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Black Lung, coronary artery disease, chronic atrial fibrillation, diabetes mellitus type 2, valvular heart disease,

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Margaret A Kaiser

29c. License number: D26650

29d. Date signed (Month, Day, Year): 5/18/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Margaret Kaiser, M.D.; 13079 Garrett Hgwy; Oakland, Md 21550

State Registrar

31. Date filed (Month, Day, Year): MAY 19 1997

32. Registrar's Signature: Julie Strickler-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 17132

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: WILLIAM S. BOYER
2. Data of Death Month / Day / Year: MAY 26 1997
3. Time of Death: 12:30 pm
4a. Facility Name *(If not institution, give street and number)*: 251 CROLL DRIVE
4b. City, Town, or Location of Death: ANNAPOLIS
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 215-12-3648
6. Sex: 1☒ M 2☐ F
7. Age *(in yrs. last birthday)*: 73 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: OCT. 21 1923
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: ANNAPOLIS
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 251 CROLL DRIVE
10f. Zip Code: 21401
10g. Citizen of What Country?: US

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th — College (1-4or 5+): 0
18a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: GROUNDS KEEPER
18b. Kind of Business/Industry: US NAVAL ACADEMY

17. Father's Name *(First, Middle, Last)*: CHARLES L. BOYER
18. Mother's Name *(First, Middle, Maiden Surname)*: GEORGIANA NASH

19a. Informant's Name/Relationship *(Type, Print)*: JUNE S. BOYER (WIFE)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 251 CROLL DRIVE ANNAPOLIS, MD. 21401

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MARYLAND VETERAN CEMETERY — Date: 5/30/97
20c. Location - City or Town, State: CROWNSVILLE, MD.

21. Signature of Funeral Service Licensee: Harry B. Reese
22. Name and Address of Facility: WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Respiratory Failure — Days

Due to (or as a consequence of):
b. Pneumonia A — Weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Multiple Myeloma Palliative CA — Years

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: D31188
29d. Date signed *(Month, Day, Year)*: 5/28/97
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 600 W. Lucky Ave. Annapolis Md. 21401

State Registrar

31. Data filed *(Month, Day, Year)*: MAY 29 1997
32. Registrar's Signature: Gloria Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17133

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ANTHONY BACON

2. Date of Death Month / Day / Year: MAY 14, 1997

3. Time of Death: 10:50pm

4a. Facility Name *(If not institution, give street and number)*: NORTH ARUNDEL HOSPITAL ASSN

4b. City, Town, or Location of Death: GLEN BURNIE

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 219-38-9525

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 52 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: JULY 23 1944

9. Birthplace *(State or Foreign Country)*: MARY NEW JERSEY

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: GLEN BURNIE

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 6906 GLEN RIDGE CIRCLE

10f. Zip Code: 21061

10g. Citizen of What Country?: US

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12): 8th

College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: TRUCK DRIVER

16b. Kind of Business/Industry: ALLIED MOVING & STROAGE

17. Father's Name *(First, Middle, Last)*: UNKNOWN

18. Mother's Name *(First, Middle, Maiden Surname)*: ALICE BACON

19a. Informant's Name/Relationship *(Type, Print)*: MARSHA GORDON (DAUGHTER)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 20 SILOPANNA RD. ANNAPOLIS, MD. 21403

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: ANNAPOLIS MEM. GARDENS

Date: 5/22/97

20c. Location - City or Town, State: ANNAPOLIS, MD.

21. Signature of Funeral Service Licensee: Larry G. Reese

22. Name and Address of Facility: WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS — WK

Due to (or as a consequence of):

b. RENAL FAILURE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. AUTO-IMMUNE DEFICIENCY SYNDROME

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [✓] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

28. Place of Death *(Check only one)*: Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D43977

29d. Date signed *(Month, Day, Year)*: MAY 14 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CYNTHIA DIRETTO, MD. 301 HOSPITAL DRIVE. GLEN BURNIE MD 21061

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date Filed *(Month, Day, Year)*: MAY 22 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17134

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Lest): Paul Michael Beaver
2. Dete of Deeth — Month: May Dey: 20, Yeer: 1997
3. Time of Deeth: 2:10pm
4e. Fecility Neme (If not institution, give street and number): Chesapeake Healthcare
4b. City, Town, or Location of Death: Arnold
4c. County of Deeth: Anne Arundel

Funeral Director

5. Socie! Security Number: 168-01-4302
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 80 Yrs. — If Under 1 Yeer: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Day, Year): July19,1916
9. Birthplace (Stete or Foreign Country): Pennsylvania

Usuel Residence of Decedent

10e. Stete: MD
10b. County: Anne Arundel
10c. City, Town or Location: Arnold
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street end Number: 305 College Parkway
10f. Zip Code: 21012
10g. Citizen of Whet Country?: USA
11. Maritel Stetus: 1☐Never Merried 2☐Merried 3☒Widowed 4☐Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Reca - American Indien, Bleck, White, etc. Specify: White
15. Decedent's Educetion (Specify only highest grade completed) — Elementary/Secondery (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Furnace Installer
16b. Kind of Business/Industry: Heating Systems
17. Fether's Neme (First, Middle, Last): Michael Beaver
18. Mother's Neme (First, Middle, Meiden Surneme): Pauline Kass
19e. Informent's Neme/Reletionship (Type, Print): Judith McCoid/daughter
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 9218 Dorothy Lane, Springfield, VA 22153
20e. Method of Disposition: 1☐Buriel 2☒Cremetion 3☐Removel from Stete 4☐Donetion 5☐Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Metro Crematory
Dete: May 22 1997
20c. Locetion - City or Town, Stete: Baltimore, MD
21. Signeture of Funeral Service Licensee: ▶ [signature]
22. Neme end Address of Feciliity: Home
Barranco & Sons, P.A. Severna Park Funeral
495 GovRitchie Hwy., Severna Park, MD21146

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23e. Part1. Enter the diseese, or complicetions thet ceused the deeth. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Interval Between Onset end Death

Immediete Ceuse (Finel diseese or condition resulting in deeth)
a. Aspiration Pneumonia — 1 week
Due to (or es a consequence of):
Cerebrovascular Accident — 3 Months

Sequentielly list conditions, if eny, leeding to immediete ceuse. Enter Underlying Ceuse (Diseese or Injury thet initiated events resulting in deeth) Last
b.
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Pert II. **Other significent conditions** contributing to deeth but not resulting in the underlying ceuse given in Pert I.
Dehydration
Multi Infarct Dementia

23b. Did tobacco use contribute to the ceuse of deeth? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24e. Wes en eutopsy performed? 1☐Yes 2☒No

24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 1☐Yes 2☐No

25. Wes case referred to medical exeminer? 1☐Yes 2☒No

26. Piece of Deeth (Check only one): Hospital: 1☐Inpetient 2☐ER/Outpetient 3☐DOA — Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Menner of Deeth: 1☒Nature! 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28e. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Locetion (Street and Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒**Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2☐**Medical Exeminer**: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: ▶ [signature] Attending Doctor
29c. License number: D21684
29d. Dete signed (Month, Dey, Yeer): 5-21-97

30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): C.V. CYRIAC-MD 8109 RITCHIE HWY PASADENA, MD 21122

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

State Registrar

31. Dete filed (Month, Day, Yeer): MAY 27 1997
32. Registrer's Signeture: ▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17135

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MILDRED A. BROWN.
2. Date of Death: Month MAY Day 18 Year 97
3. Time of Death: 6:35AM
4a. Facility Name (If not institution, give street and number): Howard County General Hospital
4b. City, Town, or Location of Death: Columbia
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 217-14-3468
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 73 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec 10, 1923
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Severna Park
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 37 West Earleigh Heights Road
10f. Zip Code: 21146
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Michael Kortz
18. Mother's Name (First, Middle, Maiden Surname): Margaret I. Sckoggs

19a. Informant's Name/Relationship (Type, Print): Gordon Brown/nephew
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 170 Mabel Lane, Severna Park, MD 21146

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Glen Haven Cemetery. Date: May 21 1997
20c. Location - City or Town, State: Glen Burnie, MD

21. Signature of Funeral Service Licensee: James E. Parsons
22. Name and Address of Facility: Home Barranco & Sons, P.A. Severna Park Funeral 495 GovRitchie Hwy., Severna Park, MD21146

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	SEIZURES	36 HRS
Due to (or as a consequence of):		
b.	UROSEPSIS	36 HRS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last. Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ACUTE RENAL FAILURE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA. Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Edward W. Schaefer, Jr. M.D.
29c. License number: D18457
29d. Date signed (Month, Day, Year): MAY 18, 97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): EDWARD W. SCHAEFER, JR. MD. 11055 LITTLE PATUXENT PKWY, COLUMBIA, MD.

State Registrar

31. Date filed (Month, Day, Year): MAY 27 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17136

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert Lansing Benjamin, Sr.

2. Date of Death: Month May, Day 25, Year 1997

3. Time of Death: 08:20 am

4a. Facility Name (If not institution, give street and number): 108 Susquehannock Blvd.

4b. City, Town, or Location of Death: North East

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 214-14-3221

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Yaer: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): August 26, 1919

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Cecil

10c. City, Town or Location: North East

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 108 Susquehannock Blvd.

10f. Zip Coda: 21901

10g. Citizen of What Country?: United States

11. Maritel Stetus: 1 ☐ Navar Married 2 ☒ Merried 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Evar in U,S. Armed Forcas? 1 ☒ Yes 2 ☐ No. If Yes, Give Yeer or Detes: U.S. Navy WWII

13. Was Decedent of Hispenic Origin? (Specify Yas or No- If Yes, specify Cuben, Maxican, Puarto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade compleated): Elementery/Secondery (0-12): 12; College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter

16b. Kind of Business/Industry: Self-employed Home building & remodelling

17. Fether's Name (First, Middle, Last): Victor Benjamin

18. Mother's Name (First, Middle, Meiden Sumame): Alvia Goodnow

19a. Informant's Name/Relationship (Type, Print): Elsie L. Benjamin / Spouse

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 108 Susquehannock Blvd., North East, MD 21901

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): North East Methodist Cem. Date: May 28 1997

20c. Location - City or Town, Steta: North East, Maryland

21. Signeture of Funeral Service Licensee: Robert E. Crouch

22. Name and Address of Facility: Crouch Funeral Home, 127 South Main Street, North East, MD 21901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter tha moda of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one ceuse on eech line. (Approximete Interval Batween Onsat and Deeth)

Immediete Ceuse (Finel disease or condition resulting in deeth): e. Cancer (Metastatic Osteosarcoma)

Due to (or es a consequence of):

Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in deeth) Lest:

b.

Due to (or es e consequence of):

c.

Due to (or es a consequence of):

d.

Part II. **Other significant conditione** contributing to daath but not rasulting in tha underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes en eutopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were eutopsy findings available prior to completion of cause of daath? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

28. Place of Death (Check only one): Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☑ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Neturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Invasfigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yas 2 ☐ No

28d. Dascribe how injury occurred

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end manner as stated. 2 ☐ **Medical Examiner:** On tha basis of axamination and/or invasfigation, in my opinion, death occurred at tha fima, date and piece, and dua to the cause(s) end menner stated.

29b. Signature and Title of certifier: Promila Suri MD

29c. Licansa number: D 33099

29d. Data signed (Month, Day, Year): 5/27/97

30. Neme and eddress of person who completed cause of death (Item 23e) (Type, Print): PROMILA SURI MD PROMILA SURI, M.D. 135 Calbedral Street ELKTON, MD 21921

State Registrar

31. Dete filed (Month, Day, Year): MAY 27 1997

32. Registrar's Signature: Julia Davidson-Gonzales

FOR REPORT ONLY

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17137

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Brookie Oxier Brown

2. Date of Death Month: May Day: 19 Year: 1997

3. Time of Death: 5:40 a.m.

4a. Facility Name *(If not institution, give street and number)*: Calvert Manor Healthcare Center

4b. City, Town, or Location of Death: Rising Sun

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 232-52-8440

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 25,1915

9. Birthplace *(State or Foreign Country)*: West Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Cecil

10c. City, Town or Location: Rising Sun

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 114 Woody Brown Road

10f. Zip Code: 21911

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): Eight Years | College (1-4or 5+): ------

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Personal Residence

17. Father's Name *(First, Middle, Last)*: Charlie Cook

18. Mother's Name *(First, Middle, Maiden Surname)*: Julie Barber

19a. Informant's Name/Relationship *(Type, Print)*: Donna J. Coy (Daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 112 Woody Brown Road, Rising Sun, Maryland 21911

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: West Nottingham Cemetery

Date: 5/22/97

20c. Location - City or Town, State: Colora, Maryland

21. Signature of Funeral Service Licensee: Thomas M. Patterson, Sr.

22. Name and Address of Facility: Lee A. Patterson & Son Funeral Home, Perryville, Maryland 21903-0188

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Lung CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

- ASCVD
- ANEMIA
- DEPRESSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: T. Biondo MD

29c. License number: 042800

29d. Date signed *(Month, Day, Year)*: 5/20/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Thomas A. Biondo, M.D., 281 East Main Street, Rising Sun, Maryland 21911

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 21 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17138

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): VERNON BUTLER
2. Dete of Deeth — Month: May Dey: 16, Yeer: 1997
3. Time of Deeth: 11:00 AM
4e. Feclity Neme (If not institution, give street and number): 4773 Bryantown Road
4b. City, Town, or Location of Death: Waldorf
4c. County of Deeth: Charles

Funeral Director

5. Socie! Security Number: 220-26-6936
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 67 Yrs. — If Under 1 Yeer: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Yeer): May 11, 1930
9. Birthpleca (Stete or Foreign Country): Maryland

Usuel Residence of Decedent

10e. Stete: Maryland
10b. County: Charles
10c. City, Town or Location: Waldorf
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street end Number: 4773 Bryantown Road
10f. Zip Code: 20601
10g. Citizen of Whet Country?: USA

11. Meritel Stetus: 1☐Never Merried 2☒Married 3☐Widowed 4☐Divorcad
12. Wes Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: 7/8/52 6/18/54
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐Yes 2☒No Specify:
14. Race - American Indien, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondary (0-12): 12 — College (1-4or 5+):
16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Auto Mechanic
16b. Kind of Business/Industry: P.G. Board of Education

17. Fether's Neme (First, Middle, Last): Alfred Lee Butler
18. Mother's Neme (First, Middle, Meiden Surneme): Mary M. Tolson

19e. Informant's Name/Reletionship (Type, Print): Cleo L. Butler Wife
19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code): 4773 Bryantown Road Waldorf, Maryland 20601

20e. Method of Disposition: 1☒Burial 2☐Cremetion 3☐Removal from State 4☐Donetion 5☐Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Maryland Veterans Cemetery
Dete: May 22, 1997
20c. Location - City or Town, State: Cheltenham, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Neme end Address of Facility: Adams Funeral Home 20605 Aquasco Road Aquasco 20608 Maryland

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23e. Pert I. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one ceuse on eech line. — Approximete Intervel Between Onset end Death

Immediete Ceuse (Finel diseese or condition resulting in deeth): e. Cancer of the tongue
Due to (or es e consequence of):
Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet Initieted events resulting in deeth) Lest:
b.
Due to (or es e consequence of):
c.
Due to (or es e consequenca of):
d.

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Wes en autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings evelleble prior to completion of cause of deeth? 1☐Yes 2☒No

25. Wes case referred to medical examiner? 1☐Yes 2☐No

26. Place of Deeth (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Menner of Deeth: 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigetion 6☐Could not be determined

28e. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☑ **Certifying Phyeician**: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the cause(s) end manner as stated. 2☐ **Medical Examiner**: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the cauee(s) end menner stated.

29b. Signeture end title of certifier: [signature]
29c. License number: D22574
29d. Date signed (Month, Dey, Yeer): 5/16/97

30. Neme end address of person who completed cause of death (Item 23e) (Type, Print)
R. TIMOTHY PACE, M.D.
MICHAEL A. LEATHERWOOD, M.D.
P.O. BOX 249
WALDORF, MD 20601

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

State Registrar

31. Dete filed (Month, Dey, Yeer): MAY 23 1997
32. Registrer's Signeture: Julia Strickson-Randall

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17139

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JOSEPH A. BIAS

2. Date of Death Month Day Year: MAY 8 1997

3. Time of Death: 11:35 pm

4a. Facility Name *(If not institution, give street and number)*: 55 CLAY STREET

4b. City, Town, or Location of Death: ANNAPOLIS

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 212-32-3785

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 64 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: OCT. 26 1932

9. Birthplace *(State or Foreign Country)*: MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: ANNAPOLIS

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 55 CLAY STREET

10f. Zip Code: 21401

10g. Citizen of What Country?: US

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6th | College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SANITATION DEPT.

16b. Kind of Business/Industry: CITY OF ANNAPOLIS

17. Father's Name *(First, Middle, Last)*: ISAAC BIAS

18. Mother's Name *(First, Middle, Maiden Surname)*: DAISY PETERS

19a. Informant's Name/Relationship *(Type, Print)*: LILLIE ALEXANDER (SISTER)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 24 CARVER ST. APT. B5 ANNAPOLIS, MD. 21401

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: ANNAPOLIS MEM. GARDENS

Date: 5/15/97

20c. Location - City or Town, State: ANNAPOLIS, MD.

21. Signature of Funeral Service Licensee: Larry G. Reese

22. Name and Address of Facility: WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC PROSTATE CANCER — 20 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: Home

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: E W Cole MD

29c. License number: D16354

29d. Date signed *(Month, Day, Year)*: MAY 16, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. Cole 900 Bestgate Rd. Suite 300 Annapolis, Md. 21401

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 19 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

97 17140

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): GEORGE DELMAR BAUMGARDNER			2. DATE OF DEATH: MONTH MAY DAY 17, YEAR 1997	3. TIME OF DEATH: 11:40 A M
4. SOCIAL SECURITY NUMBER: 218-32-1124	5. SEX: 1 X M 2 ☐ F	6. AGE (In yrs. last birthday): 83 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): JULY 18, 1913	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): CARROLL COUNTY GENERAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: WESTMINSTER	9c. COUNTY OF DEATH: CARROLL	

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: CARROLL	10c. CITY, TOWN OR LOCATION: TANEYTOWN	10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO
10e. STREET AND NUMBER: 413 EAST BALTIMORE STREET		10f. ZIP CODE: 21787	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: WORLD WAR II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: CAUCASIAN

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11th; College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): DELIVERY/ROUTE SALESMAN	16b. KIND OF BUSINESS/INDUSTRY: BAKERY PRODUCTS	
17. FATHER'S NAME (First, Middle, Last): GEORGE ROTH BAUMGARDNER		18. MOTHER'S NAME (First, Middle, Maiden Surname): EDITH ALVERTA CURRENS	
19a. INFORMANT'S NAME (Type/Print): THOMAS D. BAUMGARDNER, SON		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 206 BRIDGE DRIVE JOPPATOWNE, MARYLAND 21085	

20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place): SMITHSBURG CREMATORY	DATE: 5/18/97	20c. LOCATION — City or Town, State: SMITHSBURG, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ P. Kevin Judy		22. NAME AND ADDRESS OF FACILITY: 136 EAST BALTIMORE STREET SKILES FUNERAL HOME TANEYTOWN, MARYLAND	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Pneumonia	1wk
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypoalbuminemia, history of CA of prostate, history of renal stones, history of peptic Ulcer.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: T. A. Zaydan MD	29c. LICENSE NUMBER: D 51010	29d. DATE SIGNED (Month, Day, Year): ▶ May 27, 1997

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mohammad Zaydan, MD, Carroll County Hospital

31. DATE FILED (Month, Day, Year): MAY 19 1997	32. REGISTRAR'S SIGNATURE: Julia Strecker Randall

DHMH-16 Rev 1/89

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17141

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Bertha Wheeler Bledsoe
2. Data of Death Month Day Yaar: May 22, 1997
3. Tima of Death: 5:06 PM
4a. Facility Neme (If not institution, give straat and number): 75 Glymont Road
4b. City, Town, or Location of Deeth: Indian Head
4c. County of Deeth: Charles

Funeral Director

5. Social Security Number: 214-32-8992
6. Sax: 1☐ M 2☒ F
7. Age (In yrs. last birthday) Yrs.: 87
If Under 1 Year Months / Days; If Under 24 Hrs. Hours / Min.:
8. Date of Birth (Month, Day, Year): April 26, 1910
9. Birthplace (State or Foreign Country): Maryland

Usual Raidance of Dacedent

10e. Stata: Maryland
10b. County: Charles
10c. City, Town or Location: Indian Head
10d. Insida City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 75 Glymont Road
10f. Zip Code: 20640
10g. Citizen of What Country?: U.S.A.

11. Maritel Stetus: 1☐ Nevar Merried 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Evar in U,S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Yaar or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:
14. Rece - American Indien, Black, Whita, atc. Specify: White

15. Decedent's Education (Spacify only highest grada completed): Elamentary/Secondery (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Giva kind of work done during most of working lita. DO NOT use retired): Homemaker
16b. Kind of Businass/Industry: Her Home

17. Fathar's Nama (First, Middle, Last): Winton E. Wheeler
18. Mother's Nama (First, Middle, Maiden Sumame): Jesse Camelia Wright Wheeler

19a. Informant's Name/Relationship (Type, Print): Juanita J. Anderson Daughter
19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code): 303 Bland Dr., Indian Head, Md. 20640

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Spacify)
20b. Place of Disposition (Nama of cematary, crematory or othar place): Trinity Memorial Gardens
Data: May 27, 1997
20c. Location - City or Town, Stata: Waldorf, Maryland

21. Signature of Funeral Service Licensee: M00668
22. Nama and Address of Facility: Williams Funeral Home, P.A. 4270 Hawthorne Rd., Indian Head, Md. 2064

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causa on each lina. Approximeta Intarval Between Onset end Death

Immediata Causa (Final disaasa or condition resulting in daath)
a. CARDIAC ARRHYTHMIA
Dua to (or as a consequance of):
b. HYPERTENSIVE HEART AND CORONARY DISEASE

Sequentially list conditions, if any, leading to immediata causa. Entar Underlying Cause (Disaasa or injury that initiated events resulting in daath) Last
Dua to (or as a consequence of):
c. HEART BLOCK
Dua to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Wara autopsy findings available prior to completion of causa of death? 1☐ Yes 2☐ No

25. Was casa rafarred to medical examiner? 1☐ Yes 2☒ No
26. Place of Daath (Check only ona) Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA Othar: 4☐ Nursing Homa 5☒ Basidanca 6☐ Othar (Spacify)

27. Mannar of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding Invastigation 6☐ Could not be determined
28a. Data of Injury (Month, Day Year)
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28e. Place of Injury - At home, farm, streat, factory, office building, atc. (Specify)
28f. Location (Street end Number or Rural Routa Number, City or Town, Stata)

29a. Cartifier (Check only one): 1☒ **Certifying Physician:** To tha best of my knowledga, deeth occurred at tha tima, data and place, end dua to tha cause(s) end manner as stated. 2☐ **Medical Examinar:** On tha basis of examinetion and/or invastigation, in my opinion, daath occurred at tha tima, data and piace, and dua to the causa(s) and menner stetad.

29b. Signetura end titla of cartifiar: Ramakrishna
29c. Licensa number: D-16132
29d. Dete signed (Month, Day, Year): May 24, 1997

30. Nama end address of parson who completed causa of daath (Item 23a) (Type, Print): Nallan Ramakrishna, MD
7-D Post Office Road, Cenna Center Waldorf, Maryland 20602

State Registrar

31. Data filad (Month, Day, Year): MAY 2 8 1997
32. Registrar's Signatura: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17142

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jeannette Marie Barnes

2. Date of Death (Month, Day, Year): May 28 1997

3. Time of Death: 5:30PM

4e. Facility Name (If not institution, give street and number): 518 Long Point Road

4b. City, Town, or Location of Death: Grasonville

4c. County of Death: Queen Anne's

Funeral Director

5. Social Security Number: 168-24-5851

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 65 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 13, 1931

9. Birthplace (State or Foreign Country): Penn.

Usual Residence of Decedent

10a. State: Md.

10b. County: Queen Anne's

10c. City, Town or Location: Grasonville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 518 Long Point Road

10f. Zip Code: 21638

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Business owner

16b. Kind of Business/Industry: Ceramics

17. Father's Name (First, Middle, Last): William E. Rice

18. Mother's Name (First, Middle, Maiden Surname): Frances McKnight

19e. Informant's Name/Relationship (Type, Print): Herman T. Barnes-Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 518 Long Point Road; Grasonville, Md. 21638

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Sharon Hills Memorial Park

Date: June 4, 1997

20c. Location - City or Town, State: Dover, Del.

21. Signature of Funeral Service Licensee: Thomas K. Hellenbein

22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 106 Shamrock Rd., Chester, Md. 21619

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. CONGESTIVE HEART FAILURE — 2 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last

b. ADENOCARCINOMA OF UNKNOWN PRIMARY — 3 mo.

Due to (or as a consequence of): WITH EXTENSIVE BONE METASTASES

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Helen A Noble MD

29c. License number: D 41587

29d. Date signed (Month, Day, Year): 5/29/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Helen A. Noble, M.D.; 122 Speer Rd., Chestertown, Md. 21620

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): MAY 30 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17143

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GLORIA Y. BONNER

2. Date of Death Month: MAY Day: 19 Yaar: 1997

3. Tima of Death: 1:52 AM

4a. Facility Nama (If not institution, give street end number): Suburban Hospital

4b. City, Town, or Location of Daath: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Numbar: 227-66-3336

6. Sex: 1☐ M 2☒ F

7. Aga (In yrs. last birthdey): 48 Yrs.

If Undar 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Year): 9/18/48

9. Birthplaca (State or Foreign Country): VA

Usual Rasidanca of Dacadant

10a. Stata

10b. County

10c. City, Town or Location: Washington, D.C.

10d. Inside City Limits: 1☒ Yas 2☐ No

10e. Street and Numbar: 4829 3rd Street, N.W. #4

10f. Zip Coda: 20011

10g. Citizen of What Country?: U.S.A.

11. Maritel Status: 1☐ Navar Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Dacedant Ever in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yes, Giva Yaar or Datas:

13. Was Decedant of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxicen, Puerto Rican, etc.) 1☐ Yas 2☒ No Specify:

14. Race - Amarican Indian, Black, Whita, atc. Specify: Black

15. Dacedant's Education (Specify only highest grede completed)

Elamentary/Sacondary (0-12): 12

Collega (1-4or 5+):

16a. Dacedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Voucher Examiner

16b. Kind of Businass/Industry: U.S. Govt.

17. Fathar's Nama (First, Middle, Last): Samuel E. Hall, Sr.

18. Mothar's Nama (First, Middle, Maiden Surneme): Myrtle Thompson

19a. Informant's Name/Ralationship (Type, Print): Norman Bonner

19b. Mailing Addrass (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code): 4829 3rd St., N.W. #4 Wash., D.C. 20011

20a. Mathod of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Ramoval from Stata 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other place): Shiloh Baptist Church

Data: 5/22/97

20c. Location - City or Town, Stata: Reedville, VA

21. Signatura of Funeral Service Licensee: William O. Ables

William O. Ables

22. Name and Addrass of Facility: Hall Brothers Funeral Home 621 Florida Avenue, N.W. Wash., D.C.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: if item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disaasa, or complications thet caused tha daeth. Do not enter the mode of dying, such es cardiac or raspiretory errest, shock, or haart failura. List only ona causa on aach lina.

Approximete Intarval Batween Onsat and Death

Immedieta Causa (Finel disaesa or condition rasulting in death)

a. sepsis

Dua to (or as e consaquance of):

Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaase or injury thet initietad avants rasulting in daath) Lest

b. methicillin resistant staph/pulmonia

Dua to (or as a consequance of):

c.

Dua to (or es e consequance of):

d.

Part II. **Other significant conditions** contributing to daath but not resulting in tha undarlying ceuse givan in Part I.

multiple sclerosis

copd

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of causa of death? 1☐ Yas 2☐ No

25. Was cesa rafarrad to medical examinar? 1☐ Yes 2☐ No

26. Placa of Daath (Check only one)

Hospital: 1☐ Inpatiant 2☒ ER/Outpatiant 3☐ DOA

Othar: 4☐ Nursing Homa 5☐ Residence 8☐ Othar (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not ba datarmined

28a. Data of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Cartifying Physician:** To tha best of my knowladga, death occurred et the tima, data and place, and due to tha causa(s) and menner as steted.

2☐ **Medical Examinar:** On tha basis of axamination and/or Invastigation, in my opinion, daath occurred at tha tima, date and place, and dua to tha cause(s) and manner stetad.

29b. Signatura and title of certifier: Elliot R Goldstein

29c. Licensa numbar: D0 3581

29d. Data signed (Month, Dey, Year): 5/19/97

30. Nama and address of person who completed cause of daath (Item 23a) (Typa, Print): Elliot R. Goldstein 1299 Lamberton Dr. Silver Spring, MD.

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours efter death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Data filed (Month, Dey, Year): MAY 21 1997

32. Registrar's Signatura

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended #3. P.D., DC, 5/29/97

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17144

Physician /Medical Examiner

1. Decadant's Nama (First, Middle, Last)	2. Data of Death Month	Day	Yaar	3. Tima of Death
Madeline Danielle Biller	May	20,	1997	2:~~00~~ 20 Pm

4a. Facility Nama (If not institution, giva straat and number)	4b. City, Town, or Location of Daath	4c. County of Death
8511 48th Avenue	College Park	Prince George's

Funeral Director

5. Social Security Numbar	6. Sax	7. Aga (In yrs. last birthday)	If Under 1 Yaar: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Data of Birth (Month, Day, Yaar)	9. Birthplaca (State or Foraign Country)
216-40-6978	1☐ M 2☒ F	54 Yrs.					Dec. 10, 1942	Washington, DC

Usual Residanca of Decadant

10a. Stata	10b. County	10c. City, Town or Location	10d. Insida City Limits
Maryland	Prince George's	College Park	1☒ Yas 2☐ No

10e. Street and Number	10f. Zip Coda	10g. Citizan of What Country?
8511 48th Avenue	20740	U.S.A.

11. Marital Status	12. Was Dacadant Evar in U.S. Armad Forcas?	13. Was Dacadant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.)	14. Raca - American indian, Black, Whita, atc.
1☐ Navar Marriad 2☐ Marriad 3☒ Widowad 4☐ Divorcad	1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:	1☐ Yas 2☒ No Specify:	Specify: White

15. Dacadant's Education (Specify only highast grada complatad)		16a. Dacadent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratirad)	16b. Kind of Business/Industry
Elamantary/Secondary (0-12)	Collaga (1-4or 5+)		
	2	Budget Analyst	University of Maryland

17. Father's Nama (First, Middla, Last)	18. Mothar's Nama (First, Middla, Maidan Surnama)
Daniel Ferry	Madeline R. Hardy

19a. Informant's Name/Ralationship (Type, Print)	19b. Mailing Address (Straat and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda)
Nicole Smith - Daughter	8511 48th Avenue, College Park, Maryland 20740

20a. Method of Disposition	20b. Placa of Disposition (Neme of cematary, cramatory or othar placa)	Data	20c. Location - City or Town, Stata
1☐ Burial 2☒ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Spacify)	Metropolitan Crematory	05/21/97	Alexandria, Virginia

21. Signatura of Funaral Sarvica Licansea	22. Nama and Addrass of Facility
▶ Nancy J. Thompson	Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. Part1. Entar the disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or heart failura. List only ona causa on each lina.

		Approximata Interval Batwaan Onsat and Daath
Immadiata Causa (Final disaasa or condition resulting in daath)	a. Adenocarcinoma Ovary, metastatic	2 yrs
Sequantially list conditions, if any, leading to immadiata causa. Entar Underlying Causa (Diseasa or injury that initiated avants resulting in daath) Last	b. Due to (or as a consaquanca of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequanca of):	

Part ii. **Other significant conditions** contributing to death but not resulting in tha underlying cause givan in Part I.

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performad?	24b. Wara autopsy findings available prior to complation of causa of daath?
1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown	1☐ Yas 2☒ No	1☐ Yas 2☐ No

25. Was casa rafarrad to madical axaminar?	26. Placa of Daath (Check only ona)	
1☐ Yas 2☒ No	Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA	Other: 4☐ Nursing Homa 5☒ Rasidanca 6☐ Other (Specify)

27. Mannar of Death	28a. Data of Injury (Month, Day, Yaar)	28b. Tima of Injury	28c. Injury at Work?	28d. Describa how injury occurrad
1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding Investigation 6☐ Could not be determinad	N/A	M	1☐ Yas 2☐ No	
	28e. Placa of injury - At homa, farm, straat, factory, offica building, atc. (Specify)			28f. Location (Straat and Numbar or Rural Routa Numbar, City or Town, Stata)

29a. Certifiar (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at tha time, data and placa, and due to the causa(s) and mannar as stated.
2☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, death occurred at tha tima, data and placa, and dua to tha causa(s) and mannar stated.

29b. Signatura and titla of cartifiar	29c. Licansa numbar	29d. Data signed (Month, Day, Yaar)
▶ Paul A. DeVore, M.D.	D01852	May 21, 1997

30. Nama and addrass of parson who completad causa of death (Item 23a) (Type, Print)
Paul A. DeVore, M.D. 4203 Queensbury Road, Hyattsville, Maryland 20781

State Registrar

31. Data filed (Month, Day, Yaar)	32. Registrar's Signature
MAY 22 1997	Julie Henderson Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17145

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ronald Dennis Brotherton

2. Date of Death: Month: May; Day: 18; Year: 1997

3. Time of Death: 3:15 pm

4a. Facility Name (If not institution, give street and number): Mariner Health Care Center

4b. City, Town, or Location of Death: Laurel

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 219-48-8778

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 49 Yrs.

If Under 1 Year: Months; Days

If Under 24 Hrs.: Hours; Min.

8. Date of Birth (Month, Day, Year): Nov 27, 1947

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Columbia

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 6532 Wingflash Lane

10f. Zip Code: 21045

10g. Citizen of Whet Country?: U.S.A.

11. Maritel Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Rece - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 9

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sheet Metal Mechanic

16b. Kind of Business/Industry: Architect of the Capitol

17. Father's Name (First, Middle, Last): Jesse Roosevelt Brotherton

18. Mother's Neme (First, Middle, Maiden Surneme): Hazel Mary Clark

19a. Informant's Neme/Relationship (Type, Print): Joan I. Brotherton - Wife

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 6532 Wingflash Lane, Columbia MD 21045

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other pleca): Fort Lincoln Cemetery

Date: 5/21/97

20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: ▶ Claudette L. Gasch

22. Name and Address of Facility: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville MD 20781

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart feilure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediete Cause (Finel disease or condition resulting in deeth)

a. Huntington's Chorea

Due to (or as e consequence of):

Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lest

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Pneumonia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residenca 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Tima of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how Injury occurred

28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and piece, end due to the cause(s) and menner as stated. 2 [ ] **Medicat Examinar:** On the basis of examination and/or Investigation, In my opinion, death occurred at the time, date end placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD

29c. License number: D25430

29d. Date signed (Month, Dey, Year): May 19, 1997

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): John Marcelis, MD 14333 Laurel Bowie Rd #307 Laurel, MD 20708

State Registrar

31. Date filed (Month, Dey, Year): MAY 22 1997

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mentel Hygiene.

Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

97-2330-037
B.K.S

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 17146

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: PHILLIP BARNES
2. Date of Death Month / Day / Year: APRIL 27, 1997
3. Time of Death: 1631 PM
4a. Facility Name *(If not institution, give street and number)*: PAX RIVER HOSPITAL E.R.
4b. City, Town, or Location of Death: LEXINGTON
4c. County of Death: ST.MARY'S

Funeral Director

5. Social Security Number: 217-28-1760
6. Sex: 1 ■ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 61 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: October 27,1935
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Lexington Park
10d. Inside City Limits: 1 ☐ Yes 2 ■ No
10e. Street and Number: Route 4, Box 5
10f. Zip Code: 20653
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ■ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ■ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ■ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Carpenter
16b. Kind of Business/Industry: General Construction

17. Father's Name *(First, Middle, Last)*: James Eugene Barnes
18. Mother's Name *(First, Middle, Maiden Surname)*: Annie Carey Edgerton

19a. Informant's Name/Relationship *(Type, Print)*: Shary P. Barnes, Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 46553 Valley Court, Lexington Park, Maryland 20653

20a. Method of Disposition: 1 ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Immaculate Heart of Mary Cemetery | Date: 5-3-97
20c. Location - City or Town, State: Lexington Park, Maryland

21. Signature of Funeral Service Licensee: ▶ Edward N. Brinsfield, Jr., M00052
22. Name and Address of Facility: Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, Maryland 20650-0279

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. *(Approximate Interval Between Onset and Death)*

Immediate Cause (Final disease or condition resulting in death)
e. Head Injuries
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Diabetes mellitus
Seizure Disorder

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? partial 1 ☒ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner? ☒ Yes 2 ☐ No
26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*
27. Manner of Death: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*: 4-22-97
28b. Time of Injury: ~10 A M
28c. Injury at Work? 1 ☐ Yes 2 ☒ No
28d. Describe how injury occurred: subject fell
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: Street
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: Rt 235

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Dennis J. Chute MD
29c. License number: O.C.M.E
29d. Date signed *(Month, Day, Year)*: APRIL 28, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 05 1997
32. Registrar's Signature: ▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17147

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ELEANOR C. BICKERTON

2. Date of Death (Month, Day, Year): MAY 21, 1997

3. Time of Death: 6:56 A.M.

4a. Facility Name *(If not institution, give street and number)*: MARINER HEALTH CARE

4b. City, Town, or Location of Death: LAUREL

4c. County of Death: PRINCE GEORGE'S

Funeral Director

5. Social Security Number: 213-38-1499

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 83 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: JULY 7, 1913

9. Birthplace *(State or Foreign Country)*: VIRGINIA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: PRINCE GEORGE'S

10c. City, Town or Location: COLLEGE PARK

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 4816 BLACKFOOT ROAD

10f. Zip Code: 20740

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7 — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SALESPERSON

16b. Kind of Business/Industry: RETAIL

17. Father's Name *(First, Middle, Last)*: ROBERT LEWIS CORBIN

18. Mother's Name *(First, Middle, Maiden Surname)*: SOPHRONIA McINTOSH

19a. Informant's Name/Relationship *(Type, Print)*: RUBY J. GATES, DAUGHTER

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4816 BLACKFOOT ROAD, COLLEGE PARK, MD 20740

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: FORT LINCOLN CEMETERY

Date: 5/24/97

20c. Location - City or Town, State: BRENTWOOD, MARYLAND

21. Signature of Funeral Service Licensee: Louis L. Grant

22. Name and Address of Facility: FORT LINCOLN FUNERAL HOME, 3401 BLADENSBURG RD., BRENTWOOD, MD 20722

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia — 1 week

Due to (or as a consequence of):
b. Osteoporosis — 10 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Date of Injury *(Month, Day, Year)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Andrew Kuenhardt MD

29c. License number: 036716

29d. Date signed *(Month, Day, Year)*: MAY 21, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Andrew Kuenhardt M.D. 8317 Cherry Lane, Laurel, Md. 20707

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 22 1997

32. Registrar's Signature: Judith Sheridan-Randall

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17148

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: William Herbert Backhurst
2. Date of Death Month Day Year: May 1, 1997
3. Time of Death: 6:32 p.m.
4a. Facility Name *(If not institution, give street and number)*: 46198 Pegg Lane
4b. City, Town, or Location of Death: Great Mills
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 277-32-1623
6. Sex: 1■ M 2☐ F
7. Age *(In yrs. last birthday)*: 55 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: October 4, 1941
9. Birthplace *(State or Foreign Country)*: Michigan

Usual Residence of Decedent

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Great Mills
10d. Inside City Limits: 1☐ Yes 2■ No
10e. Street and Number: 46198 Pegg Lane, P.O. Box 254
10f. Zip Code: 20634
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2■ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1■ Yes 2☐ No — If Yes, Give Year or Dates: Vietnam
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2■ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Non-commissioned Officer
16b. Kind of Business/Industry: Navy/US Defense

17. Father's Name *(First, Middle, Last)*: Roland Backhurst
18. Mother's Name *(First, Middle, Maiden Surname)*: Jean Abitibi Young

19a. Informant's Name/Relationship *(Type, Print)*: Margaret R. Backhurst, Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 46198 Pegg Lane, P.O. Box 254, Great Mills, Maryland 20634-0254

20a. Method of Disposition: 1☐ Burial 2■ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory
Date: 5-2-97
20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Edward N. Brinsfield, Jr., M00052
22. Name and Address of Facility: Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, Maryland 20650-0279

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List *only one* cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Carcinomatosis — 6 mo.
Due to (or as a consequence of): b. Carcinoma of Breast — yrs.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of): c.
Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2■ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2■ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5■ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29e. Certifier *(Check only one)*: 1■ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. Patrick Jarboe, M.D.
29c. License number: D06419
29d. Date signed *(Month, Day, Year)*: May 2, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Patrick Jarboe, M.D., Medical Arts Building, Leonardtown, Maryland 20650

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 02 1997
32. Registrar's Signature: Judi Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1041

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17149

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CONSTANCE ELEANOR YOUNG BROWN

2. Date of Death Month Day Year: May 1, 1997

3. Time of Death: 19:55

4a. Facility Name *(If not institution, give street and number)*: Atlantic Hospital

4b. City, Town, or Location of Death: Berlin

4c. County of Death: Worchester

Funeral Director

5. Social Security Number: 217-30-6635

6. Sex: 1☐ M 2■ F

7. Age *(In yrs. last birthday)*: 63 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: August 4, 1933

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Glen Burnie

10d. Inside City Limits: 1■ Yes 2☐ No

10e. Street and Number: 7938 Rock Berry Drive

10f. Zip Code: 21061

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4■ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2■ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2■ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): / College (1-4or 5+): 6

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Teacher/Administration

16b. Kind of Business/Industry: Public Schools

17. Father's Name *(First, Middle, Last)*: Stephen Robert Leo Young, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Frances Yates

19a. Informant's Name/Relationship *(Type, Print)*: Alice R. Neal, Personal Representative

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 14178 Oaks Road, Charlotte Hall, Maryland 20622

20a. Method of Disposition: 1■ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Our Lady's Church Cemetery

Date: 5-9-97

20c. Location - City or Town, State: Medley's Neck, Leonardtown, Maryland

21. Signature of Funeral Service Licensee: Edward N. Brinsfield, Jr., MD0052

22. Name and Address of Facility: Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, Maryland 20650-0279

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. [illegible] — 2 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] physician

29c. License number: H44283

29d. Date signed *(Month, Day, Year)*: 5/5/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert Durk... 9733 Healthway Drive Berlin MD

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 07 1997

32. Registrar's Signature: [signature] Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17150

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Cora Althea Banks
2. Date of Death Month / Day / Year: May 14, 1997
3. Time of Death: 1955
4a. Facility Name *(If not institution, give street and number)*: St. Mary's Hospital
4b. City, Town, or Location of Death: Leonardtown
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 030-16-2265
6. Sex: 1☐ M 2☒ F
7. Age *(in yrs. last birthday)*: 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: August 5, 1914
9. Birthplace *(State or Foreign Country)*: Maine

Usual Residance of Dacedant

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Hollywood
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 26332 Cherry Lane
10f. Zip Coda: 20636
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yas, Giva Year or Dates:
13. Was Dacedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1☐ Yas 2☒ No *Specify:*
14. Raca - Amarican Indian, Black, White, atc. *Specify:*

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use ratired)*: Nurse
16b. Kind of Businass/Industry: Medicine

17. Father's Nama *(First, Middle, Last)*: Herman Renaldo Dearborn
18. Mothar's Nama *(First, Middle, Maiden Surneme)*: Emily Mehitable Davis

19a. Informant's Name/Relationship *(Type, Print)*: Pamela L. LeFave Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 26332 Cherry Lane, Hollywood, MD 20636

20a. Method of Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*
20b. Place of Disposition *(Name of cametery, crematory or other place)*: Metropolitan Crematory
Data: 5/16/97
20c. Location - City or Town, Stata: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Edward N. Brinsfield, Jr. M00052
22. Name and Address of Facility: Brinsfield Funeral Home, P.A. P.O. Box 279, Leonardtown, MD 20650

Physician /Medical Examiner

23a. Part1. Enter the disaase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilura. List *only* one cause on each lina.

		Approximata Intarval Between Onset and Death
Immediata Causa (Finai disaasa or condition rasulting in death) a.	Cardiac arrest	immediate
Dua to (or as a consequenca of): b.	Severe congestive heart failure	years
Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disaasa or injury that initiated avants rasulting in death) Last — Dua to (or as a consequence of): c.	Chronic obstructive pulmonary disease	years
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the undarlying cause givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yas 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Wara autopsy findings available prior to completion of cause of daath? 1☐ Yes 2☐ No

25. Was case refarred to medical examinar? 1☐ Yas 2☒ No
26. Piaca of Daath *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatiant 3☐ DOA | Othar: 4☐ Nursing Homa 5☐ Rasidanca 6☐ Othar *(Specify)*
27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined
28a. Data of injury *(Month, Day Year)*
28b. Tima of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Dascribe how injury occurred
28a. Placa of Injury - At homa, farm, streat, factory, offica building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Cartifier *(Check only one)*: 1☒ **Certifying Phyaician:** To tha best of my knowledga, daath occurred at tha tima, data and placa, and due to the causa(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of examination and/or invastigation, in my opinion, daath occurred at tha tima, data and placa, and due to the cause(s) and mannar stated.

29b. Signatura and titia of cartifiar: MD
29c. License number: D42597
29d. Date signed *(Month, Day, Year)*: 5-15-97

30. Nama and address of person who complated cause of death (Item 23a) (Type, Print): Jeffrey C. Brown, M.D. 22576 Mac Arthur Boulevard, California, Maryland 20619

State Registrar

31. Data filed *(Month, Day, Year)*: MAY 16 1997
32. Registrar's Signature: Gabi Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

parmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

(6)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17151

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mari Etta Bland
2. Date of Death: Month May Day 18, Year 1997
3. Time of Death: 0300
4e. Facility Name (If not institution, give street end number): St. Mary's Hospital
4b. City, Town, or Location of Death: Leonardtown
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 224-60-8810
6. Sex: 1☐ M 2☐ F
7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 23, 1916
9. Birthplace (State or Foreign Country): Georgia

Usual Residence of Decedent

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Lexington Park
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 23101 Town Creek Drive
10f. Zip Code: 20653
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Civil Servant
16b. Kind of Business/Industry: U.S. Government

17. Father's Name (First, Middle, Last): Noah P. Head
18. Mother's Name (First, Middle, Maiden Surname): Lillian Hulsey

19a. Informant's Name/Relationship (Type, Print): Charles D. Evans Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 23101 Town Creek Drive, Lexington Park, MD 20653

20e. Method of Disposition: 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Jackson City Cemetery
Date: 5/22/97
20c. Location - City or Town, State: Jackson, Georgia

21. Signature of Funeral Service Licensee: Edward N. Brinsfield, Jr. M00052
22. Name and Address of Facility: Brinsfield Funeral Home, P.A. P.O. Box 279, Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. MYOCARDIAL INFARCTION — 2 weeks.

Due to (or as a consequence of):
b. CONGESTIVE HEART FAILURE — " "

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. ATHEROSCLEROTIC HEART DISEASE — " "

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 8☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number: D 34539.
29d. Date signed (Month, Day, Year): MAY 19, 1997.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Khalid M. Husain, M.D. 22576 MacArthur Boulevard, California, MD 20619

State Registrar

31. Date filed (Month, Day, Year): MAY 19 1997
32. Registrar's Signature: Maria Hamilton-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17152

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Isabella Kane Barnes
2. Date of Death (Month, Day, Year): May 17, 1997
3. Time of Death: 10:55 a
4a. Facility Name (If not institution, give street and number): Patuxent River Naval Hospital
4b. City, Town, or Location of Death: Patuxent River
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 579-26-8406
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): October 30, 1923
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Scotland
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 49830 Hayes Beach Road
10f. Zip Code: 20687
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Beautician
16b. Kind of Business/Industry: Beauty Shop

17. Father's Name (First, Middle, Last): Samuel Kane
18. Mother's Name (First, Middle, Maiden Surname): Laura Beale

19a. Informant's Name/Relationship (Type, Print): Sylvester J. Barnes Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 49830 Hayes Beach Road, Scotland, Maryland 20687

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Immaculate Heart of Mary
Date: 5/21/97
20c. Location - City or Town, State: Lexington Park, MD

21. Signature of Funeral Service Licensee: Edward N. Brinsfield, Jr. M00052
22. Name and Address of Facility: Brinsfield Funeral Home, P.A. P.O. Box 279, Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Sudden Death — Minutes

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Acute Myocardial Infarction
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Acting Dep. Med Ex MD
29c. License number: D25230
29d. Date signed (Month, Day, Year): 5/20/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David Allen, MD 2050 Wildewood Ctr, California MD 20619

(6)

State Registrar

31. Date filed (Month, Day, Year): MAY 21 1997
32. Registrar's Signature: Julia Dawson-Randall

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17153

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Annie Elizabeth Brobst
2. Date of Death (Month, Day, Year): May 23, 1997
3. Time of Death: 2:35 AM
4a. Facility Name (If not institution, give street and number): St. Mary's Nursing Center
4b. City, Town, or Location of Death: Leonardtown
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 212-30-8489
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sep 2, 1905
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Mechanicville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: P.O. Box 635
10f. Zip Code: 20659
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 1 year
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk
16b. Kind of Business/Industry: U.S. Government

17. Father's Name (First, Middle, Last): Thomas Garner Reeves, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Katherine Billingsley Lyon

19a. Informant's Name/Relationship (Type, Print): William R. Mattingly/Nephew
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 23, Mechanicsville, Maryland 20659

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Christ Episcopal Cemetery
Date: 5/27/97
20c. Location - City or Town, State: Chaptico, Maryland

21. Signature of Funeral Service Licensee: Michael K. Gardiner
22. Name and Address of Facility: Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death: Months

Immediate Cause (Final disease or condition resulting in death): e. Failure of major organ systems

Due to (or as a consequence of): age/senile

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of): exacerbated by recent hip fracture

c. and by breast carcinoma (August 1996)

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Eugene Guazzo, M.D.
29c. License number: DO 2159
29d. Date signed (Month, Day, Year): 5/23/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Eugene Guazzo, M.D. Chaptico, MD 20621

State Registrar

31. Date filed (Month, Day, Year): MAY 27 1997
32. Registrar's Signature: Julie Davidson-Randall

DHMH 16 Rev 6/95

6

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17154

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Erma Jane Buckler
2. Date of Death Month Day Year: May 26, 1997
3. Time of Death: 12:45p.m.
4a. Facility Name *(If not institution, give street and number)*: St. Mary's Hospital
4b. City, Town, or Location of Death: Leonardtown
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 220-34-3961
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 62 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Aug 31, 1934
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Mechanicsville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: P.O. Box 252
10f. Zip Code: 20659
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*
Elementary/Secondary (0-12): 8th Grade
College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Arthur Edward Raley
18. Mother's Name *(First, Middle, Maiden Surname)*: Janie Rosetta Buckler

19a. Informant's Name/Relationship *(Type, Print)*: Janice Gail Farrell/Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P.O. Box 465, Charlotte Hall, MD 20622

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Charles Memorial Gardens
Date: 5/30/97
20c. Location - City or Town, State: Leonardtown, MD

21. Signature of Funeral Service Licensee: Michael L. Gardiner
22. Name and Address of Facility: Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute Bilateral Pneumonia — 48hr

Due to (or as a consequence of):
b. Severe COPD with Cor Pulmonale — 10yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*
Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number: D19917
29d. Date signed *(Month, Day, Year)*: 5/27/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. James C. Boyd Leonardtown MD. 20650

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 28 1997
32. Registrar's Signature: Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME ERMA JANE BUCKLER

DHMH 16 Rev 6/95

97-2870-031
CIP
JOHN BRENNAN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17155

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: John Bosco Brennan
2. Date of Death (Month, Day, Year): MAY 25, 1997
3. Time of Death: 6:30AM
4a. Facility Name *(If not institution, give street and number)*: 9470 SEVEN LOCKS ROAD
4b. City, Town, or Location of Death: BETHESDA
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 120-42-9441
6. Sex: 1 ■ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 30 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: November 15, 1966
9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: California
10d. Inside City Limits: 1 ☐ Yes 2 ■ No
10e. Street and Number: 23239 Rosewood Court
10f. Zip Code: 20619
10g. Citizen of What Country?: United States

11. Marital Status: 1 ■ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ■ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ■ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): College (1-4or 5+): 3
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Beverage Manager
16b. Kind of Business/Industry: Food & Beverage Industry

17. Father's Name *(First, Middle, Last)*: William Edward Brennan III
18. Mother's Name *(First, Middle, Maiden Surname)*: Paula Ann Morrissey

19a. Informant's Name/Relationship *(Type, Print)*: Paula A. Brennan, Mother
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 23239 Rosewood Court, California, Maryland 20619

20a. Method of Disposition: 1 ☐ Burial 2 ■ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory
Date: 5-28-97
20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Michael K. Blankenship, #00857
22. Name and Address of Facility: Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, Maryland 20650-0279

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Intra-Oral Gunshot Wound

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☒ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No
26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☒ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*: 5-25-97
28b. Time of Injury: 4:40 AM
28c. Injury at Work? 1 ☐ Yes 2 ☒ No
28d. Describe how injury occurred: self inflicted gunshot wound
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: home
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: 9470 Seven Locks Rd Bethesda, Md

29a. Certifier *(Check only one)*: 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Dennis J. Chute MD
29c. License number: O.C.M.E.
29d. Date signed *(Month, Day, Year)*: MAY 25, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis J. Chute, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 30 1997
32. Registrar's Signature: Julia Davidson Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17156

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Marie Adelaide Bittner

2. Data of Death Month / Day / Yaar: May 14, 1997

3. Time of Death: 7:15 am

4a. Facility Name *(If not institution, giva street and number)*: 3604 Millers Rd.

4b. City, Town, or Location of Death: Street

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 214-30-5503

6. Sax: 1☐M 2☒F

7. Age *(In yrs. last birthday)*: 91 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: Oct. 21, 1905

9. Birthplaca *(Stata or Foreign Country)*: Pennsylvania

Usual Rasidanca of Dacedant

10a. Stata: MD

10b. County: Harford

10c. City, Town or Location: Street

10d. Inside City Limits: 1☐Yas 2☒No

10e. Street and Number: 3604 Millers Road

10f. Zip Coda: 21154

10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1☐Navar Marriad 2☐Married 3☒Widowed 4☐Divorcad

12. Was Decedant Evar in U.S. Armed Forces? 1☐Yas 2☒No If Yas, Giva Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐Yas 2☒No *Specify:*

14. Raca - American Indian, Black, Whita, atc. *Specify:* White

15. Decadant's Education *(Specify only highast grada compiatad)*: Elamantary/Secondary (0-12): 12; Collaga (1-4or 5+): 3

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratired)*: Nurse

16b. Kind of Businass/Industry: Health care

17. Fathar's Nama *(First, Middla, Last)*: Robert Hayes Miller

18. Mothar's Nama *(First, Middla, Maidan Surnama)*: Ella Mae Booser

19a. Informant's Name/Ralationship *(Type, Print)*: John C. Bittner/son

19b. Mailing Address *(Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 3604 Millers Rd., Street, MD 21154

20a. Mathod of Disposition: 1☒Burial 2☐Cramation 3☐Ramoval from Stata 4☐Donation 5☐Othar *(Specify)*

20b. Place of Disposition *(Nama of camatary, cramatory or othar placa)*: Mountain View Cemetery

Data: 5/17

20c. Location - City or Town, Stata: Union Bridge, MD

21. Signature of Funaral Service Licansee: ▶ [signature]

22. Nama and Address of Facility: Hartzler Funeral Home, Union Bridge, MD

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Entar the disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only ona causa on aach lina.

Approximata Intarval Batwaan Onsat and Death

Immediata Causa (Final disaasa or condition rasulting in daath)
a. Metastatic Breast Carcinoma

Dua to (or as a consaquanca of):
b.

Saquantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that initiatad avants rasulting in daath) Last
Dua to (or as a consaquanca of):
c.

Dua to (or as a consaquanca of):
d.

Part II. **Other significant conditiona** contributing to death but not rasulting in tha undarlying causa givan in Part I.

Hypertension
Non-Insulin Dependant Diabetes Mellitus

23b. Did tobacco uae contributa to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy parformed? 1☐Yas 2☒No

24b. Wara autopsy findings available prior to completion of cause of daath? 1☐Yas 2☐No

25. Was casa rafarrad to medical examinar? 1☐Yas 2☒No

26. Placa of Daath *(Chack only ona)*: Hospital: 1☐Inpatiant 2☐ER/Outpatiant 3☐DOA; Othar: 4☐Nursing Homa 5☒Rasidanca 6☐Othar *(Specify)*

27. Manaar of Death: 1☒Natural 2☐Accidant 3☐Suicida 4☐Homicida 5☐Panding invastigation 6☐Could not be datarmined

28a. Data of injury *(Month, Day Year)*

28b. Tima of Injury M

28c. Injury at Work? 1☐Yas 2☐No

28d. Dascribe how injury occurrad

28a. Placa of Injury - At homa, farm, street, factory, office building, atc. *(Specify)*

28f. Location *(Straat and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifiar *(Chack only one)*: 1☒**Certifying Physician:** To tha best of my knowladga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as statad. 2☐**Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar statad.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29b. Signatura and title of cartifiar: ▶ Robert S. Knight MD

29c. Licansa number: 038833

29d. Data signad *(Month, Day, Year)*: 05/19/97

30. Nama and address of parson who completed causa of daath (Item 23a) (Type, Print): 104 Robert S. Knight MD 104 Mountain Rd. Ste 102 Bel Air, MD 21014

State Registrar

31. Data filed *(Month, Day, Year)*: MAY 22 1997

32. Registrar's Signatura: [signature]

DHMH 16 Rav 6/95

97-2836-043
ML
DONALD W.BURGER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17157

Physician /Medical Examiner

1. Decedant's Name *(First, Middle, Last)*: DONALD WILLIAM BURGER
2. Dete of Deeth — Month: MAY Dey: 22 Yeer: 1997
3. Time of Deeth: 11:00 AM
4e. Feclity Neme *(If not institution, give street end number)*: 309 WOODPOINT AVENUE
4b. City, Town, or Location of Deeth: HAGERSTOWN
4c. County of Deeth: WASHINGTON

Funeral Director

5. Sociel Security Number: 220-18-1510
6. Sex: 1☐ M 2☐ F
7. Age *(In yrs. last birthday)*: 71 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Yeer)*: Oct. 26,1925
9. Birthplace *(Stete or Foreign Country)*: Maryland

Usuel Residence of Decedent

10e. Stete: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 309 Woodpoint Avenue
10f. Zip Code: 21740
10g. Citizen of Whet Country?: U.S.A.

11. Mertel Stetus: 1☐ Never Merried 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No — If Yes, Give Yeer or Detes: WWII
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12 — College (1-4or 5+):
16e. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Car Inspector
16b. Kind of Business/Industry: Railroad

17. Fether's Neme *(First, Middle, Last)*: William Henry Burger
18. Mother's Neme *(First, Middle, Maiden Surname)*: Mary R. Mills

19a. Informent's Neme/Reletionship *(Type, Print)*: Cora G. Burger
19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 309 Woodpoint Avenue Hagerstown, Maryland 21740

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Othar *(Specify)*
20b. Piece of Disposition *(Name of cemetery, crematory or other piece)*: Rose Hill Cemetery — Dete: May 27, 1997
20c. Location - City or Town, Stete: Hagerstown,Maryland

21. Signeture of Funerel Service Licensee: Douglas A. Fiery
22. Neme end Address of Feclity: Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown,Maryland 21742

Physician /Medical Examiner

23e. Pert1. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or hert failure. List only one cause on each line. — Approximete Interval Between Onset and Death

Immedieta Ceusa (Final diseese or condition resulting in death): a. Arteriosclerotic Cardiovascular Disease

Due to (or es a consequence of):

Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or Injury that Initieted events resulting in deeth) Lest:
b.
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? inspection 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☒ Yes 2☐ No
26. Plece of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Dete of Injury *(Month, Dey Yeer)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. 2☒ **Medical Examiner:** On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) end menner steted.

29b. Signeture end title of certifier: Donald G. Wright MD
29c. License number: O.C.M.E.
29d. Dete signed *(Month, Dey, Yeer)*: MAY 23,1997

30. Neme and address of person who completed causa of deeth (Item 23a) (Type, Print): Donald G. Wright M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed *(Month, Day, Year)*: MAY 28 1997
32. Registrar's Signeture: Elsie Strickner Rader

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 17158

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Enid Watts Busse

2. Date of Death — Month: May; Day: 13; Year: 1997

3. Time of Death: 5:55 p.m.

4a. Facility Name *(If not institution, give street and number)*: Heron Point Nursing Center

4b. City, Town, or Location of Death: Chestertown

4c. County of Death: Kent

Funeral Director

5. Social Security Number: 083-16-5203

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 89 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 17, 1907

9. Birthplace *(State or Foreign Country)*: New Jersey

Usual Residance of Decedant

10a. State: Maryland

10b. County: Kent

10c. City, Town or Location: Chestertown

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 481 Heron Point

10f. Zip Coda: 21620

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Navar Marriad 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedant Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No — If Yas, Give Yaar or Datas:

13. Was Dacedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1☐ Yas 2☒ No *Specify:*

14. Race - American Indian, Black, Whita, atc. *Specify:* White

15. Decedant's Education *(Specify only highest grade completed)*: Elamantary/Secondary (0-12): 12; Collaga (1-4or 5+): 8

16a. Decedent's Usual Occupation *(Giva kind of work done during most of working lifa. DO NOT usa ratirad)*: Real Estate Broker/Owner

16b. Kind of Business/Industry: Real Estate

17. Father's Nama *(First, Middle, Last)*: Arthur Watts

18. Mothar's Nama *(First, Middle, Maiden Surnama)*: Eliza Jane Watts

19a. Informant's Name/Raiationship *(Type, Print)*: Ann B. Kellam/Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 324 Lime Landing Road, Millington, Maryland 21651

20a. Mathod of Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramoval trom Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Name of cematary, cramatory or other place)*: Chesapeake Cremation Center, LLC — Data: May 14, 1997

20c. Location - City or Town, Stata: Stevensville, Maryland

21. Signature of Funeral Service Licensee: Kirk J. Helfenbein

22. Nama and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart tailura. List only ona causa on aach lina.

Approximata Intarval Batwaen Onsat and Daath

Immediata Cause (Final diseasa or condition rasulting in daath)

a. METASTATIC BREAST CANCER

Due to (or as a consequance of):

Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Diseasa or Injury that initiatad avants rasulting in daath) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to daath but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yas 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to complation of causa of daath? 1☐ Yas 2☐ No

25. Was casa rafarrad to madical axaminar? 1☐ Yas 2☒ No

26. Placa of Death *(Check only ona)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Othar: 4☒ Nursing Homa 5☐ Rasidance 8☐ Othar *(Specify)*

27. Manaar of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding Invastigation 8☐ Could not be datarmined

28a. Data of Injury *(Month, Day Yaar)*

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. *(Spacify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifiar *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledga, death occurred at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and placa, and dua to tha cause(s) and mannar stated.

29b. Signatura and titla of certifiar: John C. Seymour MD

29c. Licansa number: 17-13824

29d. Data signed *(Month, Day, Year)*: 5-14-97

30. Name and addrass of parson who completed causa of daath (Itam 23a) (Type, Print): John Seymour, MD, 122 Speer Road, Chestertown, Maryland 21620

State Registrar

31. Data filed *(Month, Day, Year)*: MAY 16 '97

32. Registrar's Signatura: Julia Davidson-Randall

DHMH 16 Rav 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

12

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17159

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROBERT MEREDITH BOSTIC

2. Date of Death Month Day Year: May 20, 1997

3. Time of Death: 2:15 PM

4a. Facility Name (If not institution, give street and number): 7471 Watersville Rd.

4b. City, Town, or Location of Death: Mt. Airy

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 234-46-7409

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 66 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 19, 1930

9. Birthplace (State or Foreign Country): W. Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Mt. Airy

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 7471 Watersville Rd.

10f. Zip Code: 21771

10g. Citizen of What Country? United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 51-54

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [ ] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sales

16b. Kind of Business/Industry: Printing supplies

17. Father's Name (First, Middle, Last): Arthur Lee Bostic

18. Mother's Name (First, Middle, Maiden Surname): Sylvia Ellen Satterfield

19a. Informant's Name/Relationship (Type, Print): Gertrude Bostic / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7471 Watersville Rd./ Mt. Airy, Md. 21771

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Prospect Cemetery

Date: 5-23-97

20c. Location - City or Town, State: Mt. Airy, Maryland

21. Signature of Funeral Service Licensee: Ryan M. Dem

22. Name and Address of Facility: Stauffer Funeral Home, 8 E. Ridgeville Blvd./ Mt. Airy, Md. 21771

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. GASTRIC CARCINOMA — 6 MOS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Edward Kruter MD

29c. License number: D35398

29d. Date signed (Month, Day, Year): May 21, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Edward Kruter, M.D. 684A Pooke Rd Westminster, MD 21157

State Registrar

31. Date filed (Month, Day, Year): MAY 23 1997

32. Registrar's Signature: Julia Davidson Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

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Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17160

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary Barnes — Mary Evelyn Barnes
2. Date of Death: May 16 1997
3. Time of Death: 0735
4a. Facility Name *(If not institution, give street and number)*: THE JOHNS HOPKINS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-14-1521
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 73 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sept 6 1923
9. Birthplace *(State or Foreign Country)*: Baltimore MD

Usual Residence of Decedent

10a. State: MD
10b. County: Frederick
10c. City, Town or Location: Brunswick
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 27 East "B" Street
10f. Zip Code: 21716
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife
16b. Kind of Business/Industry: Homemaker

17. Father's Name *(First, Middle, Last)*: James William McMahon
18. Mother's Name *(First, Middle, Maiden Surname)*: Lulu Viola Jones

19a. Informant's Name/Relationship *(Type, Print)*: Penny D. Barnes
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 11320 Baker Road, Keyman, MD 21757

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Park Heights Cemetery — Date: 5/20
20c. Location - City or Town, State: Brunswick, MD

21. Signature of Funeral Service Licensee: Barbara A. Williams
Barbara A. Williams, Owner
22. Name and Address of Facility: John T. Williams Funeral Home
100 Petersville Road, Brunswick, MD 21716

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	pulmonary hemorrhage	8-12 hours
Due to (or as a consequence of):	Coagulopathy	8-12 hours
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of):	chronic myelogenous leukemia	5-10 years
c. Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
pseudomonas bacteremia
Staphylococcus bacteremia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No
25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: RES000
29d. Date signed *(Month, Day, Year)*: May 16, 1997
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JAY EPSTEIN JOHNS HOPKINS HOSPITAL BALTIMORE MARYLAND

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 20 1997
32. Registrar's Signature: Lisa Davidson Rudolph

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17161

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Bettie Jeanne Barker
2. Date of Death (Month, Day, Year): May 15, 1997
3. Time of Death: 1:36 p.m.
4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 297-05-2345
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan 25, 1918
9. Birthplace (State or Foreign Country): Pennsylvania

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Mt. Airy
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1242 Long Corner Road
10f. Zip Code: 21771
10g. Citizen of Whet Country?: United States
11. Marital Status: 1☐ Never Married 2☐ Merried 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American indien, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): -
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Secretary
16b. Kind of Business/Industry: Law Office
17. Father's Name (First, Middle, Lest): David Philip Shrum
18. Mother's Name (First, Middle, Malden Surname): Maude May Howell
19a. Informent's Neme/Reletionship (Type, Print): Joan R. Wood / daughter-in-law
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 694 1242 Long Corner Rd., Mt. Airy, MD 21771
20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Piece of Disposition (Name of cemetery, cremetory or other piece): Hagerstown Crematory
Date: 5/17/97
20c. Location - City or Town, State: Hagerstown, Maryland
21. Signature of Funerel Service Licensee: ▶ Paul P. B. MacKay
22. Name and Address of Facility: Stauffer Funeral Homes, P.A. 8 E. Ridgeville Blvd., Mt. Airy, MD 21771

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Pert1. Enter the disease, or complicetions thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert feilure. List only one cause on each line.

		Approximate Interval Between Onset end Death
Immediate Ceuse (Finel diseese or condition resulting in death) a.	Respiratory failure	3 weeks
Due to (or as a consequence of): b.	pneumonia and chronic dostructive pulmonary disease	3 weeks
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in deeth) Last — Due to (or as e consequence of): c.	congestive heart failure	3 weeks
Due to (or as a consequence of): d.	atrial fibrillation with tachycardia	3 weeks

Pert tt. **Other stgnificant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

Breast cancer
ileus of small bowel
Sepsis

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was en eutopsy performed? 1☑ Yes 2☐ No

24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 1☐ Yes 2☑ No

25. Wes case referred to medicel exeminer? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☑ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Phyaiclen:** To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) end menner as steted. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete end piece, end due to the ceuse(s) and menner steted.

29b. Signeture and title of certifier: ▶ [signature]
29c. License number: D35695
29d. Date signed (Month, Day, Year): 5.16.97

30. Neme and address of person who completed ceuse of death (Item 23a) (Type, Print): N. ERIC CARNELL, M.D. 915 Toll House Ave. S-203 Frederick MD 21701

State Registrar

31. Date filed (Month, Dey, Yeer): MAY 19 1997
32. Registrar's Signature: ▶ Julia Davidson Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Peges 1 end 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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97-2523-001
B.K.S
HOMER
BUCKLER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17162

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: HOMER GILBERT BUCKLER

2. Date of Death Month / Day / Year: MAY 7, 1997

3. Time of Death: 6:55PM

4a. Facility Name *(If not institution, give street and number)*: MEMORIAL HOSPITAL

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 236-02-4957

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 35 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 7/24/61

9. Birthplace *(State or Foreign Country)*: Baltimore, MD

Usual Residence of Decedent

10a. State: WV

10b. County: Hardy

10c. City, Town or Location: Moorefield

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street end Number: HC 65 Box 334 (Dover Hollow Rd)

10f. Zip Code: 26836

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Excavation Contractor

16b. Kind of Business/Industry: Construction

17. Father's Name *(First, Middle, Last)*: Benjamin J. Buckler

18. Mother's Name *(First, Middle, Maiden Surname)*: Luella Poland

19a. Informant's Name/Relationship *(Type, Print)*: Leah Buckler, Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: HC 65 Box 334, Moorefield, WV 26836

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. Zion Cemetery | Date: 5/11

20c. Location - City or Town, State: Augusta, WV

21. Signature of Funeral Service Licensee: Jeffrey A. Fraley

22. Name and Address of Facility: Fraley Funeral Home, PO Box 89, Moorefield, WV 26836

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Shotgun Wound of Abdomen

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? [X] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient [X] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*: 5-7-97

28b. Time of Injury: 1740 M

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: Subject Shot

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: Drive Way

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: Dover Run Road, Hardy County W. Virginia 26836

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: O.C.M.E

29d. Date signed *(Month, Day, Year)*: MAY 8, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JASON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 19 1997

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17163

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HELEN J. BISHOP

2. Date of Death (Month, Day, Year): May 14 1997

3. Time of Death: 9:53 A.M.

4a. Facility Name (If not institution, give street and number): The Memorial HOspital and Medical Center

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 212-24-0835

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 67 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb 17, 1930

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Allegany

10c. City, Town or Location: Cumberland

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 825 Virginia Avenue

10f. Zip Code: 21502

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Black, White, etc. Specify: white

15. Decedent's Educetion (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Retired Home Sitter

16b. Kind of Business/Industry: Home Sitting

17. Father's Name (First, Middle, Last): Augustus Duckworth

18. Mother's Name (First, Middle, Maiden Surname): Myrtle (Long)

19a. Informant's Name/Relationship (Type, Print): Barbara Marple-daughter

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 308 Glade Blvd. Walkersville MD 21793

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Herman Cemetery

Date: 05/17

20c. Location - City or Town, State: Cumberland, MD

21. Signature of Funeral Service Licensee: James F. Scarpelli

22. Name and Address of Facility: Scarpelli Funeral Home Cumberland, MD 21502

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heert failure. List only one ceuse on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardiomyopathy — 1 year

Due to (or es e consequence of):

b. Coronary artery disease — 5 years

Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury thet initiated events resulting in deeth) Last

Due to (or as a consequence of):

c. Diabetes mellitus — 10 years

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings evallable prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Death (Check only one) Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 2☐ **Medical Examinar:** On the basis of exemination and/or investigetion, In my opinion, death occurred et the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D 28910

29d. Dete signed (Month, Day, Year): May 19, 1997

30. Neme and address of person who completed ceuse of death (Item 23e) (Type, Print): Dr. H.C. Merrick, Memorial Hospital Medical Bldg., Cumberland, Md. 21502

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

4

MDS

State Registrar

31. Date filed (Month, Day, Year): MAY 21 1997

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17164

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ralph F. Boyce

2. Date of Death Month/Day/Year: May 20 1997

3. Time of Death: 12:30 p.m.

4a. Facility Name (If not institution, give street and number): 5801 Catoctin Vista Drive

4b. City, Town, or Location of Death: Mt. Airy

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 233-34-5802

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec 17 1925

9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: MD

10b. County: Carroll

10c. City, Town or Location: Mt. Airy

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 5801 Catoctin Vista Drive

10f. Zip Code: 21771

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter

16b. Kind of Business/Industry: Building Construction

17. Father's Name (First, Middle, Last): Charles Elmer Boyce, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Delphia Barnhouse

19a. Informant's Name/Relationship (Type, Print): Mary Lea Boyce

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5801 Catoctin Vista Drive Mt Airy, MD 21771

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Queens Point Cemetery | Date: May 24, 1997

20c. Location - City or Town, State: Keyser, WV 26726

21. Signature of Funeral Service Licensee: Vicky Roth

22. Name and Address of Facility: Rotruck-Smith Funeral Home, 85 South Main Street Keyser, WV 26726

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. acute myocardial infarction 2 hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. severe Coronary artery disease.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HCVD, COPD ↑ Chol

S/p Prior CABG

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: D Sreala

29c. License number: D23015

29d. Date signed (Month, Day, Year): 5/20/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DINESH S. KALARIA 217 Washington Heights Westminster MD 21157

State Registrar

31. Date filed (Month, Day, Year): MAY 23 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10 YRS

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17165

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Gertrude Arletta Beals

2. Date of Death Month May Day 24, Year 1997

3. Time of Death: 1200

4a. Facility Name *(If not institution, give street and number)*: 8924 Stratford Court

4b. City, Town, or Location of Death: Owings

4c. County of Death: Calvert

Funeral Director

5. Social Security Number: 171 36 7572

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 87 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Feb. 13, 1910

9. Birthplace *(State or Foreign Country)*: IL

Usual Residence of Decedent

10a. State: MD

10b. County: Calvert

10c. City, Town or Location: Owings

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 8924 Stratford Court

10f. Zip Code: 20736

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: teacher

16b. Kind of Business/Industry: public schools

17. Father's Name *(First, Middle, Last)*: Harry Beals

18. Mother's Name *(First, Middle, Maiden Surname)*: Effie King

19a. Informant's Name/Relationship *(Type, Print)*: Connie J. Beals/daug.

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: same as 10 above

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Grandview Cemetery

Date: 5-30-97

20c. Location - City or Town, State: Allentown, PA

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Rausch Funeral Home, Owings, MD 20736

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. myocardial Infarction

Due to (or as a consequence of):

b. ASCVD

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Hypertension

Due to (or as a consequence of):

d. C.H.F

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Atherosclerosis

Hyperlipidemia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☑ Yes 2☐ No

28. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D25922

29d. Date signed *(Month, Day, Year)*: 5/26/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul V. Beals, M.D. 910 Cherry Lane, Lusby, MD 20708

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State Registrar

31. Date filed *(Month, Day, Year)*: MAY 28 1997

32. Registrar's Signature: Julie Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Item 17, 19a CCHD 5/29/97 fcb

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17166

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CLARENCE BURTON

2. Date of Death Month MAY Day 21 Year 1997

3. Time of Death: 4:23 P.M.

4a. Facility Name *(If not institution, give street and number)*: MALCOLM GROW MEDICAL CENTER

4b. City, Town, or Location of Death: ANDREWS AFB

4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 236-44-3892

6. Sex: XX 1 M 2 F

7. Age *(In yrs. last birthday)*: 65 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: July 13, 1931

9. Birthplace *(State or Foreign Country)*: West Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Upper Marlboro

10d. Inside City Limits: 1 Yes XX 2 No

10e. Street and Number: 16107 Ninean Court

10f. Zip Code: 20772

10g. Citizen of What Country?: United States

11. Marital Status: 1 Never Married 2 XX Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? XX 1 Yes 2 No

If Yes, Give Yeer or Dates: 1948 1969

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 XX No *Specify:*

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education *(Specify only highest grade completed)*

Elementery/Secondery (0-12): 12

College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT usa retired)*: Tax Assessor

16b. Kind of Business/Industry: Prince George's County

17. Father's Nama *(First, Middle, Last)*: Jessie Bryan ~~Byrton~~ BURTON

18. Mother's Name *(First, Middle, Maiden Surname)*: Carrie Lee Sutphin

19a. Informent's Name/Relationship *(Type, Print)*: Martha ~~Byrton~~ BURTON

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 16107 Ninean Court , Upper Marlboro, Md 20772

20a. Method of Disposition: XX 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Maryland Veterans Cemetery

Data: May 29, 1997

20c. Location - City or Town, State: Cheltenham, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Lee Funeral Home,Inc 6633 Old Alexandria Ferry Rd, Clinton,Md 20735

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. HEPATORENAL SYNDROME

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last

b. METASTATIC ADENOCARCINOMA TO LIVER

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 XX No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 XX No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 XX No

26. Place of Death *(Check only one)*

Hospital: 1 XX Inpatient 2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residance 8 Other *(Specify)*

27. Manner of Death: 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D43956

29d. Date signed *(Month, Day, Year)*: MAY 21 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): WILLIAM A. STINNETTE

89 MDG 1050 W. PERIMETER ROAD
ANDREWS AIR FORCE BASE MD 20762

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 27 1997

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17167

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JAMES HOLLIS BROWN
2. Date of Death Month: MAY Day: 8 Year: 1997
3. Time of Death: 2350
4a. Facility Name *(If not institution, give street end number)*: PENINSULA REGIONAL MEDICAL CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 216-40-4655
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 54 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: JAN. 3, 43
9. Birthplace *(State or Foreign Country)*: SHARPTOWN, MD.

Usual Residence of Decedent

10a. State: MD.
10b. County: WICOMICO
10c. City, Town or Location: MARDELA SPRINGS
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1150 OLD SCHOOL HOUSE ROAD
10f. Zip Code: 21837
10g. Citizan of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Giva Year or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work dona during most of working life. DO NOT use retired)*: LABORER
16b. Kind of Business/Industry: DRESSER-PUMP TESTER

17. Father's Name *(First, Middle, Last)*: CHARLES GOSLEE
18. Mother's Name *(First, Middle, Maiden Surname)*: CORA BROWN

19a. Informant's Name/Relationship *(Type, Print)*: AMY BROWN/DAUGHTER
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 9058 S.GREENWOOD AVE., CHICAGO, ILL. 60619

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, crematory or other piece)*: ZION UM CHURCH CEM.
Date: MAY 15,
20c. Location - City or Town, State: SHARPTOWN, MD.

21. Signature of Funeral Service Licentiee: ▶ Loretta D. Jolley
22. Name and Address of Facility: JOLLEY MEMORIAL CHAPEL 1213 JERSEY ROAD; SALISBURY, MD. 21801

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximata Intervel Between Onset and Death

Immediate Causa (Final disaasa or condition resulting in death)
a. Probable ventricular fibrillation

Due to (or as a consequence of):
Coronary artery disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last
b.

Due to (or as a consequence of):
Atherosclerosis

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.
S/P CABG, Hypertension Diabetes

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case refarred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospitel: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At homa, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete end piece, end due to the cause(s) and menner as steted. 2☐ **Medical Examiner:** On the besis of exemination and/or investigation, in my opinion, death occurred at the time, dete and piece, end due to the ceuse(s) and manner stated.

29b. Signatura and title of certifier: ▶ Bl Bansal
29c. License number: 17181
29d. Date signed *(Month, Day, Year)*: 5/9/97

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): BAL AGARWAL M.D. 614C EASTERN SHORE DR. SALISBURY, MD 21801

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 16 1997
32. Registrer's Signature: Julia Hamilton Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

James Brown SS# 216-40-4655

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17168

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): George Verne Carson
2. Date of Death: Month: May; Day: 19; Year: 1997
3. Time of Death: 12:30 pm
4a. Facility Name (If not institution, give street and number): Manor - Care Wheaton
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 214-18-8938
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 93 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 4, 1903
9. Birthplace (State or Foreign Country): Illinois

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Kensington
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 3708 Farragut Avenue
10f. Zip Code: 20895
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4 or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Construction
16b. Kind of Business/Industry: Self Employed

17. Father's Name (First, Middle, Last): Lafayette Carson
18. Mother's Name (First, Middle, Maiden Surname): Unknown

19a. Informant's Name/Relationship (Type, Print): Elsie M. Carson
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3708 Farragut Avenue, Kensington, MD 20895

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery
Date: 5/21/97
20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: John L Chipola
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Heart failure — 3 wks

Due to (or as a consequence of):
b. Arteriosclerotic heart disease — 30 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Marvin Wadler M.D.
29c. License number: D12068
29d. Date signed (Month, Day, Year): 20/May/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Marvin Wadler, M.D. 8218 Wisconsin Avenue Bethesda, Maryland 20814

State Registrar

31. Date filed (Month, Day, Year): MAY 21 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17169

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Marie V. Celani

2. Date of Death: Month May Day 19 Year 1997

3. Time of Death: 8:35 pm

4a. Facility Name (If not institution, give street and number): Independence Court of Hyattsville

4b. City, Town, or Location of Death: Hyattsville

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 087-24-7469

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 95 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 28, 1901

9. Birthplace (State or Foreign Country): New York

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: NY

10b. County: Brooklyn

10c. City, Town or Location: Brooklyn

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 7901 4th Avenue

10f. Zip Code: 11209

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Pasquale Castorina

18. Mother's Name (First, Middle, Maiden Surname): Agatha Archishaculo

19a. Informant's Name/Relationship (Type, Print): Robert Cangelosi

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15117 Water Oak Drive, Darnestown, MD 20878

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. Charles Cemetery

Date: 5/24/97

20c. Location - City or Town, State: Pinelawn, NY

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cardiac arrest-	4hrs.
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Myocardiopathy	> years.
Due to (or as a consequence of):		
	c. Congestive Heart failure.	> years.
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diverticulosis.

Anaemia.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Assisted living

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]

29c. License number: D19609

29d. Date signed (Month, Day, Year): MAY 20th, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RAMAN R. TULI, MD 3503 PERRY ST. MT. RAINIER MD 20712.

State Registrar

31. Date filed (Month, Day, Year): MAY 23 1997

32. Registrar's Signature: ▶ Julia Davidson-Randall

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17170

Physician /Medical Examiner

1. Decedent's Neme (First, Middla, Last): Cafiero Cicala
2. Date of Death Month / Day / Yeer: May 21, 1997
3. Time of Death: 9:30 AM
4a. Feciility Name (If not institution, give street and number): 3423 Saint Leonard's Court
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-01-6434
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 85 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Day, Year): May 20, 1912
9. Birthplace (State or Foreign Country): Washington, DC

Usuel Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 [ ] Yes 2 [ ] No
10e. Street and Number: 3423 Saint Leonard's Court
10f. Zip Code: 20906
10g. Citizen of What Country?: USA

11. Maritel Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4or 5+): 4
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Accountant
16b. Kind of Business/Industry: U.S. Government

17. Father's Name (First, Middle, Lest): Domenico Cicala
18. Mother's Name (First, Middle, Maidan Sumame): Anna Rascona

19a. Informant's Name/Relationship (Type, Print): Vincent Cicala (Cousin)
19b. Mailing Address (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Code): 11020 Cone Lane, Silver Spring, Maryland 20902

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Hill Cemetery
Date: 5-24-97
20c. Location - City or Town, State: Suitland, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Hines-Rinaldi Funeral Home 11800 New Hampshire Ave, Silver Spring, MD 20904

Physician /Medical Examiner

25. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart failure. List only one ceuse on each line.

Approximete Interval Between Onset end Death

Immediete Ceuse (Final disease or condition resulting in death): a. Acute Myocardial Infarction — 10 minutes

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobecco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was cese referred to medical exeminer? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only ona): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Deeth: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Yaar)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Spacify)
28f. Location (Straat and Number or Rural Routa Number, City or Town, Steta)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Mark S Rosen MD
29c. License number: D20400
29d. Dete signed (Month, Dey, Year): May 21, 1997

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Mark S. Rosen, MD, 3941 Ferrara Drive, Wheaton, Maryland 20902

State Registrar

31. Date filed (Month, Day, Year): MAY 23 1997
32. Registrar's Signature: Gina Wilson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17171

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Jeanette Mund Cole

2. Data of Daath Month Day Yaar: May 16, 1997

3. Tima of Death: 9:30 AM

4a. Facility Nama *(If not institution, giva street and number)*: 1817 Brisbane Street

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Numbar: 473-16-7074

6. Sax: 1☐ M 2☒ F

7. Aga *(In yrs. last birthday)*: 75 Yrs.

If Undar 1 Yaar: Months / Days

If Undar 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: Oct.21,1921

9. Birthplaca *(Stata or Foraign Country)*: Minnesota

Usual Rasidance of Decadant

10a. Stata: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Insida City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 1817 Brisbane Street

10f. Zip Coda: 20902

10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1☐ Navar Marriad 2☒ Marriad 3☐ Widowad 4☐ Divorcad

12. Was Dacadant Evar in U.S. Armad Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:

13. Was Dacadant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*

14. Race - Amarican Indian, Black, Whita, atc. *Specify:* White

15. Dacadant's Education *(Specify only highast grada compliatad)*: Elamantary/Saconday (0-12): Collaga (1-4or 5+): 2

16a. Dacadant's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratirad)*: Homamaker

16b. Kind of Businass/Industry: Own Home

17. Fathar's Nama *(First, Middla, Last)*: Edward S. Mund

18. Mothar's Nama *(First, Middla, Maidan Sumama)*: Henrietta S. Rausch

19a. Informant's Nama/Ralationship *(Type, Print)*: Gilbert A. Cole, Jr.

19b. Mailing Addrass *(Stract and Numbar or Rural Routa Numbar, City or Town, Stata, Zip Coda)*: 1817 Brisbane Street, Silver Spring, Maryland 20902

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Placa of Disposition *(Nama of camatary, cramatory or othar placa)*: St. John's Cemetery

Data: 5/19/97

20c. Location - City or Town, Stata: Forest Glen, Maryland

21. Signatura of Funaral Sarvica Licansaa: J. Kevin Gutowski

22. Nama and Addrass of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd.,W.,Sil.Spr.,Maryland 20901

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that caused tha daath. Do not antar tha mода of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina.

Approximata Intarval Batwaan Onsat and Death

Immadiata Causa (Finat disaasa or condition rasulting in daath)

a. Respiratory arrest — Approximata Intarval: minutes

Dua to (or as a consaquanca of):

b. Lung cancer — Approximata Intarval: 9 months

Saquantially list conditions, if any, laading to Immadiata ceusa. Entar Undarlying Causa (Disaasa or injury that initiatad avants rasulting in daath) Last

Dua to (or as a consaquance of):

c.

Dua to (or as a consaquance of):

d.

Part II. **Other significant conditions** contributing to daath but not rasulting in tha undarlying ceusa givan in Part I.: None

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☑ No

24b. Ware autopsy findings available prior to compliation of cause of daath? 1☐ Yas 2☐ No

25. Was cesa rafarrad to madical examinar? 1☐ Yas 2☑ No

26. Placa of Daath *(Check only ona)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA; Othar: 4☐ Nursing Homa 5☑ Rasidance 8☐ Othar *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Yaar)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurrad

28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. *(Spacify)*

28f. Location *(Straat and Numbar or Rural Routa Numbar, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1☑ **Cartifying Phyaician:** To tha bast of my knowladga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as statad. 2☐ **Madical Examinar:** On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar statad.

29b. Signatura and tita of cartifiar: Kevin J. Glass MD

29c. Licansa number: MD051171-L (PA)

29d. Data signad *(Month, Day, Yaar)*: May 16, 1997

30. Nama and addrass of parson who complatad causa of daath (Itam 23a) (Typa, Print): KEVIN L. GLASS MD, Pulmonary Clinic Walter Reed AMC Washington DC

State Registrar

31. Data filad *(Month, Day, Yaar)*: MAY 19 1997

32. Registrar's Signatura: Gina Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17172

Physician /Medical Examiner

1. Decedent's Nama *(First, Middle, Last)*: Juliana M. Corridon

2. Data of Daath — Month: May, Dey: 14, Year: 1997

3. Tima of Death: 12:45 A.M.

4e. Facility Nama *(If not institution, giva street end number)*: Potomac Valley Nursing Center

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Sociel Security Number: 578-90-3008

6. Sax: 1☐ M 2☒ F

7. Aga *(In yrs. last birthday)*: 85 Yrs. — If Under 1 Yaar: Months / Deys — If Undar 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: March 23,1912

9. Birthplece *(Stata or Foreign Country)*: Germany

Usual Residence of Decadant

10a. Stata: Maryland

10b. County: Montgomery

10c. City, Town or Location: Bethesda

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 4405 East West Highway

10f. Zip Code: 20814

10g. Citizan of What Country?: United States

11. Maritel Status: 1☐ Navar Married 2☐ Married 3☒ Widowed 4☐ Divorcad

12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No — If Yas, Giva Yaar or Datas:

13. Wes Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.): 1☐ Yas 2☒ No *Specify:*

14. Race - American Indian, Black, Whita, atc. *Specify:* White

15. Decedent's Education *(Specify only highest greda completed)*: Elamantary/Secondary (0-12): 12 — Collaga (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratired)*: Actress

16b. Kind of Businass/Industry: Theater

17. Father's Nema *(First, Middle, Last)*: Not/ Available

18. Mothar's Nama *(First, Middla, Maidan Surnama)*: Not/ Available

19a. Informant's Name/Ralationship *(Type, Print)*: Robert M. McCarthy/Guardian

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 4405 East-West Highway #201 Bethesda,Maryland 20814

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Nama of cematary, crematory or othar place)*: Arlington National Cemetery — Data: May 27,1997

20c. Location - City or Town, Stata: Arlington, Virginia

21. Signature of Funeral Service Licensee: [signature] M00335

22. Nama and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc, 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

23a. Part1. Entar tha diaeaae, or complicationa that causad tha daath. Do not enter tha moda of dying, such es cardiac or raspiratory arrast, shock, or heart failura. List only ona causa on aach lina.

Approximata Intarval Batween Onset and Death

Immadiata Causa (Final disaasa or condition resulting in daath)

a. Sepsis — 7-8 Days

Dua to (or as a consequance of):

Sequentially list conditions, if any, leading to immadiate cause. Entar Undarlying Causa (Disaasa or injury that initiated evants rasulting in daath) Last

b.

Dua to (or as a consequance of):

c.

Due to (or es e consequance of):

d.

Part II. **Other significant conditiona** contributing to death but not resulting in tha undarlying causa givan in Part I.: Gangrene Leg, Peripheral Vascular Disease; Urinary Tract Infection

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings evellable prior to complation of cause of daath? 1☐ Yas 2☒ No

25. Was casa rafarred to medical axaminer? 1☐ Yas 2☒ No

26. Placa of Death *(Check only ona)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpetient 3☐ DOA — Othar: 4☒ Nursing Homa 5☐ Rasidance 6☐ Othar *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding Invastigation 6☐ Could not be datarminad

28a. Data of Injury *(Month, Day Yaar)*

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stata)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Cartifiar *(Check only one)*: 1☒ **Certifying Phyalcian**: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha cause(s) and manner es stated. 2☐ **Medical Examinar**: On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, end dua to tha causa(s) and mannar stated.

29b. Signatura and titla of certifiar: [signature]

29c. Licansa number: D 42578

29d. Data signed *(Month, Dey, Year)*: May 14, 1997

30. Nama and addrass of person who complated causa of daath (Item 23a) (Type, Print): Gul G. Chablani, M.D., 11119 Rockville Pike, #316, Rockville, Maryland 20852

To the Hospital or Attending Physician: The law requires that tha death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attanding physician and completely filled in by the funeral director, page 2 should be detached for usa as the burial-transit

5

State Registrar

31. Data filed *(Month, Day, Year)*: MAY 21 1997

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17173

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Linda Carol Culver

2. Date of Death (Month, Day, Year): May 17 1997

3. Time of Death: 12:06PM

4e. Facility Name (If not institution, give street and number): 2316 East Gate Drive

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 214-52-4961

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 50 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 4, 1946

9. Birthplace (State or Foreign Country): Washington, D.C.

Usual Residence of Decedent

10e. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2316 East Gate Drive

10f. Zip Code: 20906

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Artist

16b. Kind of Business/Industry: Self Employed

17. Father's Name (First, Middle, Last): Edward G. Culver

18. Mother's Name (First, Middle, Maiden Surname): Geneva Cathcart

19e. Informant's Name/Relationship (Type, Print): Geneva Culver

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2316 East Gate Drive Silver Spring, Maryland 20906

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Parklawn Memorial Park

Date: 5/19/97

20c. Location - City or Town, State: Rockville, Maryland

21. Signature of Funeral Service Licensee: Monte Dodd

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Sil. Spr., Maryland 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Cardio-respiratory Arrest — 4 Mins.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Chronic Respiratory Failure — 2 Years

Due to (or as a consequence of):

c. Chronic Obstructive Pulmonary Disease — 6 Years

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Phillip W. Poth, MD

29c. License number: D 22309

29d. Date signed (Month, Day, Year): May 18, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Phillip W. Poth, M.D. 831 University Boulevard, East Silver Spring, MD 20901

State Registrar

31. Date filed (Month, Day, Year): MAY 19 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17174

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Antonia Cuna
2. Date of Death Month: May Dey: 15 Year: 1997
3. Time of Death: 1210
4a. Facility Name (If not institution, give street end number): SHADY GROVE ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 213-92-0743
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthdey): 74 Yrs. | If Under 1 Yeer: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 22 1922
9. Birthplece (State or Foreign Country): Philippines

Usuel Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Aspen Hill
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3952 Bel Pre Road
10f. Zip Code: 20906
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Merried 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - American Indian, Bleck, White, etc. Specify: Asian

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 4
16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Ceferino Bartolome Sr.
18. Mother's Name (First, Middle, Maiden Surname): Maria Mendoza

19e. Informant's Name/Relationship (Type, Print): Chona Flannery / Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4242 East West Highway Chevy Chase, Maryland 20815

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Placa of Disposition (Name of cemetery, cremetory or other piece): Ft. Lincoln Crematory
Date: 5/19/97
20c. Location - City or Town, Stete: Brentwood Maryland

21. Signature of Funeral Service Licensee: Thomas Geyer
22. Name and Address of Facility: Hines/Rinaldi Funeral Home 11800 New Hampshire Ave. Silver Spring, Md.20904

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)
a. PANCYTOPENIA — 4 YEARS

Due to (or as a consequenca of):
b. MYELODYSPLASIA — 6 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initieted events resulting in deeth) Lest

Due to (or as a consequenca of):
c.

Due to (or es e consequence of):
d.

Part II. Other significant conditfone contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No

24b. Were eutopsy findings evallable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination end/or investigetion, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: Joseph M. Haggerty MD
29c. License number: D32407
29d. Date signed (Month, Day, Year): MAY 16, 1997

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print): JOSEPH M. HAGGERTY MD 9707 MEDICAL CTR DR ROCKVILLE, MD 20850

State Registrar

31. Dete filed (Month, Day, Year): MAY 20 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician: The law requires that the death certificete be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17175

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Doris L. Cunningham

2. Date of Death Month / Day / Year: MAY 21, 1997

3. Time of Death: 0430

4a. Facility Name *(If not institution, give street and number)*: PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 379-32-8555

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 64 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan 18, 1933

9. Birthplace *(State or Foreign Country)*: Michigan

Usual Residence of Decedent

10a. State: MD

10b. County: Wicomico

10c. City, Town or Location: Parsonsburg

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 7415 Casey Way

10f. Zip Code: 21849

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:* White

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 | College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Home

17. Father's Name *(First, Middle, Last)*: George Peters

18. Mother's Name *(First, Middle, Meiden Surname)*: Nellie Simpkins Zerkel

19a. Informant's Name/Relationship *(Type, Print)*: Joanne L. Carter/Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5 E. Chestnut Street Delmar, MD 21875

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Cambridge Crematory

Date: 5-24-97

20c. Location - City or Town, State: Cambridge, MD

21. Signature of Funeral Service Licensee: William M. Short

22. Name and Address of Facility: Short Funeral Home, Inc. 13 E. Grove ST. Delmar, DE 19940

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)
a. Renal Failure — weeks

Due to (or as a consequence of):
b. Diabetes Nephropathy — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or es a consequence of):
c.

Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: sepsis, chronic congestive Heart Failure, Atherosclerotic Heart Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Constante Tan M.D.

29c. License number: 16725

29d. Date signed *(Month, Day, Year)*: MAY 21, 1997

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): TAN, CONSTANTE 547-D Riverside Dr, Salisbury, MD 21801

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 22 1997

32. Registrar's Signature: Julia Atherton Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Doris L. Cunningham

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17176

Amend. Item #8, 05/29/97, WCHD, KLH

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GEORGIA ELIZABETH CONWAY

2. Data of Death Month Day Yaar: May 22, 1997

3. Tima of Death: 4:50 AM

4a. Facility Nama (If not institution, give street and number): Salisbury Center, Genesis ElderCare

4b. City, Town, or Location of Daath: Salisbury, Md.

4c. County of Death: Wicomico

Funeral Director

5. Social Security Numbar: 217-28-3225

6. Sax: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 90 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Yaar): 2-18-1907

9. Birthplaca (State or Foreign Country): Maryland

Usual Rasidanca of Dacadant

10a. Stata: Md.

10b. County: Wicomico

10c. City, Town or Location: Salisbury

10d. Insida City Limits: 1☒ Yas 2☐ No

10e. Straat and Numbar: 200 Civic Ave.

10f. Zip Coda: 21801

10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1☒ Navar Marriad 2☐ Marriad 3☐ Widowad 4☐ Divorcad

12. Was Dacadant Evar in U.S. Armad Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:

13. Was Dacadant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:

14. Race - Amarican Indian, Black, White, etc. Specify: Black

15. Dacadant's Education (Specify only highast grada completad): Elamantary/Sacondary (0-12): 7 / Collaga (1-4or 5+):

16a. Dacadant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratirad): House Keeper

16b. Kind of Businass/Industry: Own Home

17. Fathar's Nama (First, Middla, Last): George Conway

18. Mothar's Nama (First, Middla, Maidan Surnama): Laura --------

19a. Informant's Nama/Ralationship (Typa, Print): Ann Purnell

19b. Mailing Addrass (Straat and Numbar or Rural Routa Numbar, City or Town, Stata, Zip Coda): 108 Edinburg Court, Salisbury, Md. 21801

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)

20b. Placa of Disposition (Nama of camatary, crematory or othar placa): St James Free Meth Church Date: 5/27

20c. Location - City or Town, Stata: Quantico, Md.

21. Signatura of Funaral Sarvica Licansaa: Cornelius D. Messick MOO-417

22. Nama and Addrass of Facility: Messick Funeral Home, P.O. Box 61 Bivalve, Maryland 21814

Physician /Medical Examiner

23a. Part I. Entar the disasa, or complications that causad the daath. Do not antar the mода of dying, such as cardiac or raspiratory arrast, shock, or hart failura. List only ona causa on aach lina.

Immadiata Cauca (Final disasa or condition resulting in daath):
a. Renal insufficiency — Approximata Intarval Batwaan Onsat and Daath: yrs
Due to (or as a consaquanca of):
b. Cerebrovascular accident — yrs
Due to (or as a consaquanca of):
Saquantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disasa or injury that initiatad avants rasulting in daath) Last
c. Hypertension — yrs
Due to (or as a consaquanca of):
d.

Part II. Othar significant conditions contributing to daath but not rasulting in tha underlying causa givan in Part I.

23b. Did tobacco usa contributa to tha causa of daath? 1☐ Yas 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performad? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to completion of causa of daath? 1☐ Yas 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was casa referrad to madical examinar? 1☐ Yas 2☒ No

26. Placa of Daath (Chack only one): Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA Othar: 4☒ Nursing Homa 5☐ Rasidanca 6☐ Othar (Specify)

27. Mannar of Daath: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not ba datarminad

28a. Data of Injury (Month, Day Yaar)

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurrad

28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

28f. Location (Straat and Numbar or Rural Routa Numbar, City or Town, Stata)

29a. Cartifiar (Chack only one): 1☐ Cartifying Phyaician: To tha bast of my knowladga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2☐ Madical Examinar: On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar stated.

29b. Signatura and tita of cartifiar:

29c. Licansa numbar: D-39813

29d. Data signad (Month, Day, Yaar): 5/22/97

30. Nama and addrass of parson who completad causa of daath (Itam 23a) (Typa, Print): MICHAEL ATKINS, M.D., 1104 HEALTHWAY DR., SALISBURY, MD. 21804

State Registrar

31. Data filad (Month, Day, Yaar): MAY 23 1997

32. Rajistrar's Signatura: John Davidson Randall

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To be completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17177

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Leo H. Corley
2. Date of Death Month Day Year: May 25, 1997
3. Time of Death: 12:55 P.M.
4a. Facility Name (If not institution, give street and number): Anne Arundel Medical Center
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 714-07-9046
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 19, 1912
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Mayo
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 3966 Ramsey Dr.
10f. Zip Code: 21106
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpet Installer
16b. Kind of Business/Industry: Carpet
17. Father's Name (First, Middle, Last): Albert P. Corley
18. Mother's Name (First, Middle, Maiden Surname): Mary R. Dull
19a. Informant's Name/Relationship (Type, Print): Zora M. Corley/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3966 Ramsey Dr. Mayo, Maryland 21106
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Lakemont Memorial Gardens
Date: 5/29/97
20c. Location - City or Town, State: Davidsonville, Md.
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, Md.21037

Physician /Medical Examiner

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Acute Cerebrovascular Hemorrhage — 12 hours
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] R. Scott Eden, MD
29c. License number: D30701
29d. Date signed (Month, Day, Year): 5/25/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): R. SCOTT EDEN, M.D, 1410 FOREST DR, ANNAPOLIS, MD 21403

State Registrar

31. Date filed (Month, Day, Year): MAY 29 1997
32. Registrar's Signature: [signature]

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To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17178

NAME: ANGELA DANADA COSPITO Jnr

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Angela Cospito

2. Date of Death: Month MAY Day 25, Year 1997

3. Time of Death: 5:20a.m.

4a. Facility Name (If not institution, give street and number): St. Mary's Hospital

4b. City, Town, or Location of Death: Leonardtown

4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 139-12-6150

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 16, 1906

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Florida

10b. County: St. Lucie

10c. City, Town or Location: Port St. Lucie

10d. Inside City Limits: 1☐ Yes 2☐ No

10e. Street and Number: 3070 Southwest Briggs Street

10f. Zip Code: 34953

10g. Citizen of What Country?: United States of America

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Joseph DeLeo

18. Mother's Name (First, Middle, Maiden Surname): Maria Antonia Rizzi

19a. Informant's Name/Relationship (Type, Print): Filomena Maiore/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 572 Jamaica Boulevard, Toms River, New Jersey 08757

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Holy Cross Cemetery

Date: May 29, 1997

20c. Location - City or Town, State: North Arlington New Jersey

21. Signature of Funeral Service Licensee: Karen W. Dase

22. Name and Address of Facility: Clerici Funeral Home 07087
4110 Kennedy Boulevard, Union City, New Jersey

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. PROBABLE MYOCARDIAL INFARCTION — Sec

Due to (or as a consequence of):

b. CORONARY ARTERY DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: William Boyd, M.D.

29c. License number: D14285

29d. Date signed (Month, Day, Year): 5-27-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William Boyd, M.D. 25365 Point Lookout Rd. Leonardtown, MD 20650

State Registrar

31. Date filed (Month, Day, Year): MAY 30 1997

32. Registrar's Signature: Julia Davidson-Randall

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17179

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Patricia A. Crawford

2. Date of Death Month: May Day: 21 Year: 1997

3. Time of Death: 8:20 AM

4a. Facility Name *(If not Institution, give street and number)*: 3601 Fontron Drive

4b. City, Town, or Location of Death: Edgewater

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 217-34-0156

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 65 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sept 7 1931

9. Birthplace *(State or Foreign Country)*: Massachusetts

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Edgewater

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3601 Fontron Drive

10f. Zip Code: 21037

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Nurses Aide

16b. Kind of Business/Industry: Health Industry

17. Father's Name *(First, Middle, Last)*: Thomas J. Davis

18. Mother's Name *(First, Middle, Maiden Surname)*: Rose E. Wooster

19a. Informant's Name/Relationship *(Type, Print)*: John R. Crawford (Husband)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3601 Fontron Drive Edgewater, Maryland 21037

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Lakemont Memorial Gardens

Date: 5/24/97

20c. Location - City or Town, State: Davidsonville, Maryland

21. Signature of Funeral Service Licensee: Donald A. Lyles

22. Name and Address of Facility: John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Lung Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: A. Stephen Hansman

29c. License number: D 27388

29d. Date signed *(Month, Day, Year)*: May 21, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): A. Stephen HANSMAN, 200 HARRY TRUMAN PKWY, ANNAPOLIS, MD 21401

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 22 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17180

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: VIOLA M. CLAWSON

2. Date of Death Month / Day / Year: MAY 26 1997

3. Time of Death: 1040 AM

4a. Facility Name *(If not institution, give street and number)*: NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death: GLEN BURNIE

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 412.10.9815

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 06-28-20

9. Birthplace *(State or Foreign Country)*: TENNESSEE

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: GLEN BURNIE

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 302 MARYLAND AVENUE

10f. Zip Code: 21060

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Rece - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 7 / College (1-4or 5+): none

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: AIRCRAFT WORKER

16b. Kind of Business/Industry: GLEN L. MARTIN

17. Father's Name *(First, Middle, Last)*: JAMES WAITS BARNETT

18. Mother's Name *(First, Middle, Maiden Surname)*: ELIZABETH BARNETTE

19e. Informant's Name/Relationship *(Type, Print)*: JOE R. CLAWSON (SON)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1186 MAHAGONY LANE CROWNSVILLE, MARYLAND 21032

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stete 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: HAPPY VALLEY MEM. PK.

Date: MAY 31, 1997

20c. Location - City or Town, State: ELIZABETH, TENNESSEE

21. Signature of Funeral Service Licensee: Jamie Bielat

22. Name and Address of Facility: SINGLETON FUNERAL HOME 1 SECOND AVE. S.W. GLEN BURNIE, MARYLAND 21061

Physician /Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. SEPTIC SHOCK

Due to (or as a consequence of):

b. SEVERE PERIPHERAL VASCULAR DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD.

29c. License number: D43977

29d. Date signed *(Month, Day, Year)*: MAY 26 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CYNTHIA DIETRICH, 301 HOSPITAL DRIVE. GLEN BURNIE MD 21061

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 28 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Amended Line 10d, 18 FCHD

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17181

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert L. Custer
2. Date of Death (Month, Day, Year): May 12, 1997
3. Time of Death: 3:30 AM
4a. Facility Name (If not institution, give street and number): 890 Pontiac Avenue
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 103-16-6589
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 72 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov 16, 1924
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 890 Pontiac Avenue
10f. Zip Code: 21701
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sr. Plant Operator
16b. Kind of Business/Industry: Power PEPCO/ Plant

17. Father's Name (First, Middle, Last): Leon Russell Custer
18. Mother's Name (First, Middle, Maiden Surname): Ruth ~~Mapes~~ Heil

19a. Informant's Name/Relationship (Type, Print): Rita M. Custer/ wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 890 Pontiac Avenue, Frederick, Maryland 21701

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Olivet Cemetery
Date: 5/16/97
20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: Paul P. B. MacKay
22. Name and Address of Facility: Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, Maryland 21702

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. METASTATIC ADENOCARCINOMA OF THE RECTUM	7 YEARS
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Richard O'Connor
29c. License number: D31761
29d. Date signed (Month, Day, Year): 5/12/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): O'Connor, 501 West 7th Street, Frederick, MD 21701

State Registrar

31. Date filed (Month, Day, Year): MAY 14 1997
32. Registrar's Signature: Lisa Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17182

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ellen G. H. Clark
2. Date of Death Month/Day/Year: May 11 1997
3. Time of Death: 9:45 am
4a. Facility Name (if not institution, give street and number): 15215 Seneca Road
4b. City, Town, or Location of Death: Germantown
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 122-07--751
8. Sex: 1☐ M 2☒ F
7. Age (in yrs. last birthday): 84 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Mar 25 1913
9. Birthplace (State or Foreign Country): NY

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Germantown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 15215 Seneca Road
10f. Zip Code: 20878
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): salesperson
16b. Kind of Business/Industry: retail store

17. Father's Name (First, Middle, Last): Bert William Helgren
18. Mother's Name (First, Middle, Maiden Surname): Beda Coralina Van Loeve

19a. Informant's Name/Relationship (Type, Print): Mary Markoff friend
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13904 Darnestown Rd. Darnestown, MD 20878

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Darnestown Presbyterian
Date: 5/14
20c. Location - City or Town, State: Darnestown, MD

21. Signature of Funeral Service Licensee: Wm C Hil
22. Name and Address of Facility: Hilton Funeral Home Barnesville, MD 20838

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Inoperable BRAIN TUMOR — Feb 97
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Hypertension
Osteoarthritis

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☐ inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Kevin M. Gill
29c. License number: D35192
29d. Date signed (Month, Day, Year): May 13, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kevin Gill Dufief Mill Rd Gaithersburg md

State Registrar

31. Date filed (Month, Day, Year): MAY 13 1997
32. Registrar's Signature: Julia Sheridan Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17183

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary Eleanor Cashman

2. Date of Death Month: May Day: 13 Year: 97

3. Time of Death: 1515 AM

4a. Facility Name *(If not institution, give street and number)*: Carroll Lutheran Village Health Care Center

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 213-20-3684

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 91 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Apr. 7, 1906

9. Birthplace *(State or Foreign Country)*: Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Westminster

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 205 St. Mark Way

10f. Zip Code: 21158

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11; College (1-4or 5+): 5+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: sales clerk

16b. Kind of Business/Industry: retail dept. store

17. Father's Name *(First, Middle, Last)*: Harry C. Reese, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Ida Myers

19a. Informant's Name/Relationship *(Type, Print)*: Edmond R. Cashman/ son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1025 Heritage Dr. Pawleys Island, SC 29585

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Pipe Creek Cemetery

Date: 5/16/97

20c. Location - City or Town, State: nr. Linwood, MD

21. Signature of Funeral Service Licensee: Catharine O. Hartzler

22. Name and Address of Facility: Hartzler Funeral Home, New Windsor, MD

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular accident — 1 MO.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Cancer breast → bone

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J.H. Coricoffe MD

29c. License number: D 906

29d. Date signed *(Month, Day, Year)*: 5/13/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J.H. CORICOFFE M.D P.O. Box 1110 Union Bridge, MD 21791

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 16 1997

32. Registrar's Signature: Julie Davidson Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17184

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FLORINE E. COOK

2. Date of Death: Month MAY Day 12, Year 1997

3. Time of Death: 1:00 PM

4a. Facility Name (If not institution, give street and number): FREDERICK MEMORIAL HOSPITAL

4b. City, Town, or Location of Death: FREDERICK

4c. County of Death: FREDERICK

Funeral Director

5. Social Security Number: 220-28-8422

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JULY 29, 1923

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: CARROLL

10c. City, Town or Location: MT. AIRY

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6340 DAVIS ROAD

10f. Zip Code: 21771

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 4th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): homemaker

16b. Kind of Business/Industry: own home

17. Father's Name (First, Middle, Last): Basil Dorsey II

18. Mother's Name (First, Middle, Maiden Surname): Mandila Flora Costley

19a. Informent's Name/Relationship (Type, Print): Audrey Lyles Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13828 Old Annapolis Road Mt. Airy, MD 21771

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Fairview U.M. Ch. Cemetery

Date: May 16

20c. Location - City or Town, State: Taylorsville, MD

21. Signature of Funeral Service Licensee: James B Covey

22. Name and Address of Facility: Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Road Winfield, MD 21784

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cereb. vasc. accident

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Generalized arteriosclerosis

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Insulin Dependent Diabetic Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D.

29c. License number: 026499

29d. Date signed (Month, Day, Year): 5-12-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ronald E. Miller, M.D., 4 Culwell Dr, Mt. Airy, MD 21771

State Registrar

31. Date filed (Month, Day, Year): MAY 16 1997

32. Registrar's Signature: John Gardner Kimball

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17185

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: LYNNFORD C. CAFFREY

2. Date of Death Month 5 Day 15 Year 97

3. Time of Death: 8:30PM

4a. Facility Name *(If not institution, give street and number)*: 38 Pintail Dr.

4b. City, Town, or Location of Death: Berlin

4c. County of Death: Worcester

Funeral Director

5. Social Security Number: 163-10-9606

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 87 Yrs.

If Under 1 Year: Months ___ Days ___

If Under 24 Hrs.: Hours ___ Min. ___

8. Date of Birth *(Month, Day, Year)*: 5/19/09

9. Birthplace *(State or Foreign Country)*: PA

Usual Residence of Decedent

10a. State: MD

10b. County: Worcester

10c. City, Town or Location: Berlin

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 38 Pintail Dr.

10f. Zip Code: 21811

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): ___ College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Owner/Operator

16b. Kind of Business/Industry: Plumbing/Heating

17. Father's Name *(First, Middle, Last)*: James C. Caffrey

18. Mother's Name *(First, Middle, Maiden Surname)*: Elizabeth Vaughn

19a. Informant's Name/Relationship *(Type, Print)*: Amelia Caffrey

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 38 Pintail Dr. Berlin, MD 21811

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Locustwood Mem. Park

Date: 5/19/97

20c. Location - City or Town, State: Cherry Hill, NJ

21. Signature of Funeral Service Licensee: Jason Henderson 1100284

22. Name and Address of Facility: Burbage Funeral Home 108 William St. Berlin, MD 21811

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. upper GI bleed

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. bacterial endocarditis.

Due to (or as a consequence of):

c. aortic stenosis.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J Christie MD

29c. Licensa number: D0050605

29d. Data signed *(Month, Day, Year)*: May 16. 97.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. CHRISTIE MD 9633 Healthway Dr. Berlin Md. 21811

State Registrar

31. Data filed *(Month, Day, Year)*: MAY 19 1997

32. Registrar's Signature: Julia Davidson Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

15

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 17186

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary A. Cullen

2. Date of Death (Month, Day, Year): May 21, 1997

3. Time of Death: 6:10a.m.

4a. Facility Name (If not Institution, give street and number): Edw. W.McCready Memorial Hospital

4b. City, Town, or Location of Death: Crisfield

4c. County of Death: Somerset

Funeral Director

5. Social Security Number: 229-05-5835

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 9,1920

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Somerset

10c. City, Town or Location: Crisfield

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 73 Somers Cove Apts.

10f. Zip Code: 21817

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 10 | College (1-4or 5+): - - -

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Co-owner

16b. Kind of Business/Industry: Auto Service Station

17. Father's Name (First, Middle, Last): Wilbur Powell

18. Mother's Name (First, Middle, Maiden Surname): Lula Marshall

19a. Informant's Name/Relationship (Type, Print): James H. Cullen (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 29914 Kingston Lane - Westover, MD 21871

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Asbury Cemetery | Date: 5/23/97

20c. Location - City or Town, State: Crisfield, MD

21. Signature of Funeral Service Licensee: Robert H. Bradshaw

22. Name and Address of Facility: Bradshaw & Sons Funeral Home, 306 W. Main St. - Crisfield, MD 21817

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. COPD

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: A-fibrillation; Malnutrition

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D48098

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Dr. VIJAY KARUMBUNATHAN McCready Memorial Hospital, Crisfield, Md.21817

State Registrar

31. Date filed (Month, Day, Year): MAY 27 1997

32. Registrar's Signature: Julia Lawson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17187

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROBERT EUGENE CARMAN SR.

2. Data of Death (Month, Day, Year): May 21, 1997

3. Time of Death: 9:05 AM

4a. Facility Name (If not institution, give street and number): 1560 W. Jarrettsville Road

4b. City, Town, or Location of Death: Jarrettsville

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 219-28-5481

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 64 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): 2/14/1933

9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Md.

10b. County: Harford

10c. City, Town or Location: Jarrettsville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 1560 W. Jarrettsville Road

10f. Zip Code: 21084

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No. If Yes, Give Year or Dates: Korea

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Caucasian

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 / College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Serviceman

16b. Kind of Business/Industry: L P Gas

17. Father's Name (First, Middle, Last): John Walter Carman Sr.

18. Mother's Name (First, Middle, Maiden Surname): Ruth Evelyn Cuddy

19a. Informant's Name/Relationship (Type, Print): Robert E. Carman Jr./Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1442 Chrome Hill Rd. Jarrettsville, Md. 21084

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): William Watters Cem.

20b. Date: 5/24

20c. Location - City or Town, State: Cooptown, Maryland

21. Signature of Funeral Service Licensee: M. Gladden Kurtz III

22. Name and Address of Facility: Kurtz Funeral Home, P.A. Jarrettsville, Maryland

Pursuant to Health-General Article, Section 5-307, Annotated Code of Maryland, this certificate must be filed with the Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Pages 1 and 2 should be filed within 72 hours after death with the permit. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. End Stage liver Disease

Due to (or as a consequence of):

b. Cirrhosis of the liver

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Ascites

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one) — Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Lisa S Pichney MD

29c. License number: D57183

29d. Date signed (Month, Day, Year): 5/22/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 7505 OSLER DR #307 TOWSON, MD 21204 LISA S. PICHNEY MD.

State Registrar

31. Date filed (Month, Day, Year): MAY 23 1997

32. Registrar's Signature

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17188

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARGARET COOK

2. Dete of Deeth — Month: MAY Day: 18 Yeer: 97

3. Time of Death: 5:40 am

4e. Feclity Neme (If not institution, give street and number): ST. AGNES HOSPITAL

4b. City, Town, or Location of Deeth: BALTIMORE

4c. County of Death: NONE

Funeral Director

5. Sociel Security Number: 262.38.2782

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 79 Yrs. — If Under 1 Yeer: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Day, Yeer): SEPT 23, 1917

9. Birthplece (Steta or Foreign Country): MARYLAND

Usuel Residence of Dacedent

10a. Stete: MARYLAND

10b. County: BALTIMORE

10c. City, Town or Location: CATONSVILLE

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 701 MAIDEN CHOICE LAND CHARLESTOWN RET. COMM.

10f. Zip Code: 21228

10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorcad

12. Was Decadent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Dates:

13. Was Dacadant of Hispenic Origin? (Specify Yas or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - Amarican Indian, Black, White, etc. Specify: WHITE

15. Decadent's Education (Specify only highest grede completed): Elementery/Secondery (0-12): 12 — College (1-4or 5+): NONE

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): HOME MAKER

16b. Kind of Busiress/Industry: OWN HOME

17. Fether's Neme (First, Middle, Last): WILLIAM F. BUSSEY

18. Mother's Neme (First, Middle, Maiden Surname): MARGARET TEPPER

19a. Informent's Neme/Relationship (Type, Print): BONNIE JORDAN (NIECE)

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 310 FAIRTREE DRIVE SEVERNA PARK, MD 21146

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other place): MT. CARMEL CEMETERY

Date: 5-21-97

20c. Location - City or Town, Stete: PASADENA, MARYLAND

21. Signature of Fimaral Service Licensea: [signature]

22. Nama and Address of Facility: SINGLETON FUNERAL HOME 1 SECOND AVE. SW GLEN BURNIE, MD 21061

Physician /Medical Examiner

23a. Part1. Enter the diseeses, complications that caused tha deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on eech line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death) e.	PULMONARY EDEMA	2 DAYS
Due to (or es e consequenca of):		
Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseesa or Injury thet initieted events resulting in death) Lest b.	DECOMPENSATED CONGESTIVE HEART FAILURE	10 YRS
Due to (or es e consequence of):		
c.	CARDIOMYOPATHY, HYPERTENSION	15 YRS
Due to (or es e consequanca of):		
d.		

Pert II. **Other signifIcent conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☑ No

25. Wes case referred to medical examiner? 1☐ Yes 2☑ No

26. Piece of Death (Check only one): Hospitel: 1☑ Inpatient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Phyeictan:** To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) end manner es steted. 2☐ **Medical Examiner:** On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) end manner steted.

29b. Signatura and title of certifiar: DAVID MEDICAL RESIDENT

29c. License number: A10885

29d. Date signed (Month, Dey, Yeer): MAY 18 97

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): SETH OSATO ST. AGNES HOSPITAL, 900 CATON AVE. BAL. MD 21229

State Registrar

31. Dete filed (Month, Dey, Yeer): MAY 20 1997

32. Registar's Signature: Julia Davidson-Randall

DHMH 16 Rsv 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 17189

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Cyril Boyd Cummings
2. Date of Death Month / Day / Year: May 18, 1997
3. Time of Death: 5:00 AM
4a. Facility Name *(If not institution, give street and number)*: Prince George's Hospital Center
4b. City, Town, or Location of Death: Cheverly
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 578-28-7535
6. Sex: XX M 2☐ F
7. Age *(In yrs. last birthday)*: 71 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 8/31/25
9. Birthplace *(State or Foreign Country)*: Washington, D.C.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Upper Marlboro
10d. Inside City Limits: XX 1 Yes 2☐ No
10e. Street and Number: 13610 Town Farm Rd.
10f. Zip Code: 20772
10g. Citizen of What Country?: USA

11. Marital Status: XX 1 Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? XX 1 Yes 2☐ No — If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes XX 2 No — Specify:
14. Race - American Indian, Black, White, etc. — Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th; College (1-4 or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Civil Engineer
16b. Kind of Business/Industry: Construction

17. Father's Name *(First, Middle, Last)*: Charles Cummings
18. Mother's Name *(First, Middle, Maiden Surname)*: Inez Crickenberger

19a. Informant's Name/Relationship *(Type, Print)*: Diana M. Wells/Niece
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3954 26th Ave. Temple Hills, Md. 20748

20a. Method of Disposition: 1☐ Burial 2XX Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory — Date: 5/19/97
20c. Location - City or Town, State: Alexandria, Va.

21. Signature of Funeral Service Licensee: George P. Kalas
22. Name and Address of Facility: George P. Kalas Funeral Home, 6160 Oxon Hill Rd. Oxon Hill, Md. 20745

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Chronic Renal Failure — Approximate Interval: Yrs.

Due to (or as a consequence of):
b. Anemia. — Approximate Interval: Mos.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last
Due to (or as a consequence of):
c. GI Bleeding — Approximate Interval: Wks.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4 ✓ Unknown

24a. Was an autopsy performed? 1☐ Yes 2 ✓ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2 ✓ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4 ✓ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1 ✓ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ✓ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D.
29c. License number: D41978
29d. Date signed *(Month, Day, Year)*: 5-18-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Nadi Tavakoli DOH chief. MD.

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 21 1997
32. Registrar's Signature: [signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

(1)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17190

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Joseph Cossa

2. Date of Death: Month May, Day 18, Year 1997

3. Time of Death: 6:00 pm

4a. Facility Name (If not institution, give street and number): 3204 Eton Drive

4b. City, Town, or Location of Death: Upper Marlboro

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577-58-7113

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 51 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 10, 1945

9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: MD

10b. County: Prince George's

10c. City, Town or Location: Upper Marlboro

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3204 Eton Drive

10f. Zip Code: 20772

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specity Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, atc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Owner

16b. Kind of Business/Industry: Dry Cleaning Company

17. Father's Name (First, Middle, Last): Santi William Cossa

18. Mother's Name (First, Middle, Maiden Sumeme): Mary Elizabeth Myers

19a. Informant's Name/Relationship (Type, Print): Althea D. Cossa - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3204 Eton Drive, Upper Marlboro, Maryland 20772

20a. Method of Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramoval from Stata 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Metropolitan Crematory | Date: 05/22/97

20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequance of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Asthma

Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residance 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: Deputy Medical Examiner D33954

29d. Date signed (Month, Day, Year): MAY 21, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mario F. Golle, M.D. 3001 Hospital Drive, Cheverly, Maryland 20785

State Registrar

31. Date filed (Month, Dey, Year): MAY 22 1997

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

30

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17191

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Francis Ervin Cooper

2. Date of Death Month Day Year: May 17, 1997

3. Time of Death: 12:55AM

4a. Facility Name (If not institution, give street and number): Doctor's Hospital

4b. City, Town, or Location of Death: Lanham

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 238-46-5094

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 68 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 26, 1928

9. Birthplace (State or Foreign Country): North Carolina

Usual Residance of Decedant

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Lanham

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 7907 Polk Street

10f. Zip Code: 20706

10g. Citizan of What Country?: USA

11. Marital Status: 1 ☐ Nevar Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedant Evar in U.S. Armed Forcas? 1 ☒ Yes 2 ☐ No. If Yes, Giva Yaar or Datas: 1/18/51 to 8/10/56

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1 ☐ Yas 2 ☒ No Specify:

14. Race - American indian, Black, White, atc. Specify: Black

15. Dacadant's Education (Specify only highast grada complatad): Elamantary/Secondary (0-12): 7th; Collega (1-4or 5+):

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired): Truck Driver

16b. Kind of Businass/Industry: Private

17. Father's Nama (First, Middla, Last): Sunnie E. Cooper

18. Mothar's Nama (First, Middla, Maidan Sumama): Mary Jane Battle

19a. Informant's Neme/Ratationship (Type, Print): Hazel Cooper/Wife

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): 7907 Polk Street, Lanham, Maryland 20706

20a. Mathod of Disposition: 1 ☐ Burial 2 ☐ Cramation 3 ☒ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Nama of camatary, cramatory or othar place): Gardens of Gethsemane

Data: 5/24/97

20c. Location - City or Town, Stata: Rocky Mount, NC

21. Signatura of Funaral Sarvice Licansee: [signature]

22. Nama and Address of Facility: J.B. Jenkins Funeral Home 7474 Landover Road, Landover, MD 20785

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that caused the death. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only ona causa on aach line.

Approximata Intarval Between Onsat and Death

Immediate Causa (Finat disaasa or condition resulting in death): a. SEPSIS

Due to (or as a consequance of): PNEUMONIA

Sequentially list conditions, if any, leading to immadiate cause. Entar Underlying Ceusa (Disaase or Injury thet initiated evants resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa givan in Part I.

Carcinoma of Prostate

Status post Cystectomy

23b. Did tobacco use contributa to the causa of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performad? 1 ☐ Yas 2 ☒ No

24b. Wara autopsy findings available prior to compilation of causa of death? 1 ☐ Yas 2 ☐ No

25. Was case rafarred to madical exeminar? 1 ☐ Yes 2 ☒ No

26. Place of Daath (Check only ona): Hospital: 1 ☒ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA. Othar: 4 ☐ Nursing Homa 5 ☐ Rasidanca 6 ☐ Othar (Specify)

27. Manner of Death: 1 ☒ Naturel 2 ☐ Accidant 3 ☐ Suicida 4 ☐ Homicida 5 ☐ Pending invastigation 6 ☐ Could not ba determined

28a. Data of Injury (Month, Day Yaar)

28b. Tima of Injury M

28c. Injury at Work? 1 ☐ Yas 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At homa, farm, street, factory, offica building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Certifiar (Check only one): 1 ☒ **Certifying Physician:** To tha best of my knowladge, deeth occurred at tha tima, data end placa, end dua to tha cause(s) and menner as steted. 2 ☐ **Madical Examiner:** On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, dete end place, and dua to tha cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D.

29c. Licansa number: D04841

29d. Data signed (Month, Day, Year): May 17, 1997

30. Nama and address of person who completad cause of daath (Item 23a) (Type, Print): MEHDI FARZIN 7525 Greenway CFR Dr Greensboro NC 27410

State Registrar

31. Date filed (Month, Day, Year): MAY 22 1997

32. Registrar's Signatura: [signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

FRANCIS ERVIN COOPER

10

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17192

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: FANNIE COLES

2. Date of Death: Month: May; Day: 18; Year: 1997

3. Time of Death: 0640Am

4a. Facility Name *(If not institution, giva street and number)*: HOLY CROSS HOSPITAL

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 247-32-2555

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 74 Yrs.

If Under 1 Year: Months; Days

If Under 24 Hrs.: Hours; Min.

8. Date of Birth *(Month, Day, Year)*: Oct. 4, 1922

9. Birthplece *(Stete or Foreign Country)*: Edgefield, S.C.

Usuel Residenca of Decedant

10e. Stete: District of Columbia

10b. County:

10c. City, Town or Location: Washington

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Straet end Number: 5520 C Street, S. E.

10f. Zip Coda: 20019

10g. Citizan of Whet Country?: United States

11. Maritel Status: 1☐ Navar Married 2☐ Marriad 3☒ Widowed 4☐ Divorced

12. Was Decedant Ever in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Year or Datas:

13. Was Dacadant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*

14. Raca - American Indian, Bleck, Whita, atc. *Specify:* Black

15. Decedant's Education *(Specify only highast grada completed)*: Elementary/Secondary (0-12): 12; Collaga (1-4or 5+):

16a. Dacedant's Usual Occupetion *(Giva kind of work dona during most of working lifa. DO NOT use ratired)*: Retired Postal Director

16b. Kind of Businass/Industry: Government Bethesda Naval Hospital

17. Fathar's Name *(First, Middla, Last)*: John Henry Ouzts

18. Mothar'a Nama *(First, Middle, Maidan Sumama)*: Mamie McManus

19a. Informant's Name/Ralationship *(Type, Print)*: Michael O. Coles - Son

19b. Mailing Address *(Streat and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 6905 Saddlebow Court, Clinton, Maryland 20735

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramovai from Steta 4☐ Donation 5☐ Othar *(Specify)*

20b. Placa of Disposition *(Nama of cemetary, cramatory or othar placa)*: Harmony Memorial Park

Date: 5/23/97

20c. Location - City or Town, Stale: Landover, Maryland

21. Signature of Funeral Service Licensee: John T. Stewart III

22. Nama and Address of Facility: STEWART FUNERAL HOME, Inc. 4001 Benning Road, N.E., Washington, D. C.

Physician /Medical Examiner

23a. Part I. Enter tha disaasa, or complicetions that caused tha death. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or heart failura. List only one cause on aach lina.

		Approximate Interval Between Onsat and Death
Immediata Cause (Final disease or condition resulting in daath) a.	Respiratory failure	Sudden
Due to (or as a consequenca of): b.	Empyema thoracis	Days
Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disaasa or Injury that initiated evants resulting in death) Last — Due to (or as a consequance of): c.	Pneumonia	Days
Due to (or as a consequenca of): d.	Sepsis.	Days

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying causa givan in Part I.

Diabetes Mellitus

Fever

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings available prior to completion of causa of death? 1☐ Yas 2☐ No

25. Was casa refarred to medical examinar? 1☐ Yes 2☒ No

28. Place of Death *(Check only ona)*: Hospital: 1☒ Inpatiant 2☐ ER/Outpatiant 3☐ DOA; Othar: 4☐ Nursing Homa 5☐ Rasidance 8☐ Other *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At homa, farm, streat, factory, office building, atc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stata)*

29a. Cartifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of *my* knowledga, death occurred at the tima, data and place, and due to the cause(s) and manner as steted. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigetion, in *my* opinion, death occurred at the time, dete and piece, and dua to tha causa(s) and mannar stated.

29b. Signature and title of cartifiar: M Gupta MD

29c. License number: D-32332

29d. Data signed *(Month, Day, Year)*: 05 18 97

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print): SK GUPTA MD 9801 Georgia Ave # 220 SILVER SPRING Md 20902

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 23 1997

32. Registrar's Signature: Julie Strickler Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17193

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Joseph Austin Canada

2. Date of Death Month May Day 19 Year 1997

3. Time of Death: 11:11 P.M.

4e. Facility Name *(If not institution, give street end number)*: Anne Arundel Medical Center

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 213 56 3441

6. Sex: XX M 2☐ F

7. Age *(In yrs. last birthday)*: 46 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 27, 1950

9. Birthplace *(State or Foreign Country)*: Massachusetts

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Crofton

10d. Inside City Limits: 1☐ Yes XX No

10e. Street and Number: 2046 Friendly Place

10f. Zip Code: 21114

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced XX

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates: 67-70

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2X No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+)

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Foreman

16b. Kind of Business/Industry: Sheet Metal

17. Father's Name *(First, Middle, Last)*: Frank C. Canada Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Evelyn Larkin

19a. Informant's Name/Relationship *(Type, Print)*: David W. Canada Brother

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3101 Glen Ave. Glenn Dale Md. 20769

20a. Method of Disposition: 1 XX Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Maryland Veterans Cemetery Date: May 28, 1997

20c. Location - City or Town, State: Cheltenham Maryland

21. Signature of Funeral Service Licensee: David Groom

22. Name and Address of Facility: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Md. 20715

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Cardiac Arrhythmia — Unknown

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Arteriosclerotic Heart Disease

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4X Unknown

24a. Was an autopsy performed? 1☐ Yes 2X No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1X Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2X ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1X Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2X **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: William P. Jones Deputy

29c. License number: D 06054

29d. Date signed *(Month, Day, Year)*: 5/20/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William P. Jones MD 695 America 21035

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 23 1997

32. Registrar's Signature: Julia Madison Parlett

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 17194

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: John Matthew Cooper
2. Date of Death Month / Day / Year: May 1, 1997
3. Time of Death: 4:00 p.m.
4a. Facility Name *(If not institution, give street and number)*: St. Mary's Nursing Center
4b. City, Town, or Location of Death: Leonardtown
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 219-32-1778
6. Sex: 1 ■ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 2, 1906
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Ridge
10d. Inside City Limits: 1 ☐ Yes 2 ■ No
10e. Street and Number: 49712 Bayne Road, P.O. Box 132
10f. Zip Code: 20680
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ■ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ■ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ■ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Foreman
16b. Kind of Business/Industry: State Highway Administration

17. Father's Name *(First, Middle, Last)*: Joseph Walter Cooper
18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Magdaline Lumpkins

19a. Informant's Name/Relationship *(Type, Print)*: Margaret A. Cooper, Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 49712 Bayne Road, P.O. Box 132, Ridge, Maryland 20680-0132

20a. Method of Disposition: 1 ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: St. Michael's Church Cemetery
Date: 5-5-97
20c. Location - City or Town, State: Ridge, Maryland

21. Signature of Funeral Service Licensee: Edward N. Brinsfield, Jr., M00052
22. Name and Address of Facility: Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, Maryland 20650-0279

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute Pneumonia — Days

Due to (or as a consequence of):
b. Severe Alzheimers Disease — 7 Months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Seizure Disorder

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No

28. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number: D19917
29d. Date signed *(Month, Day, Year)*: 5/2/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James Boyd, M.D. 2050 Wildewood Center, California, Maryland 20619

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 02 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

(8)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17195

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): George William Chase

2. Data of Deelh: Month MAY Day 17 Yeer 1997

3. Time of Death: 10:47AM

4a. Facility Name (If not institution, giva straet end number): St. Mary's Hospital

4b. City, Town, or Location of Death: Leonardtown

4c. County of Deeth: St. Mary's

Funeral Director

5. Social Security Number: 219-16-0563

6. Sax: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 71 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Dey, Year): January 10, 1926

9. Birthplece (Steta or Foraign Country): Maryland

To Be Completed by Funeral Director

Usuel Residence of Decedent

10a. Stete: Maryland

10b. County: St. Mary's

10c. City, Town or Location: Mechanicsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Streat end Number: 40615 Kavanaugh Road

10f. Zip Code: 20659

10g. Citizen of Whet Country?: United States

11. Maritel Stetus: 1☐ Never Merried 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yaar or Detes: 1945-1986

13. Was Decedent of Hlspenic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - Amarican Indien, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 8 College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retirad): Technician

16b. Kind of Businass/Indusiry: Maryland National Guard

17. Fethar's Name (First, Middle, Last): John Philip Chase

18. Mother's Neme (First, Middle, Meiden Surneme): Mary Catherine Nolan

19a. Informent's Name/Reletionship (Type, Print): Mary L. Chase Wife

19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 40615 Kavanaugh Road, Mechanicsville, MD 20659

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or othar place): Queen of Peace Cemetery

Date: 5/22/97

20c. Location - City or Town, Stete: Helen, Maryland

21. Signature of Funeral Service Licensee: Edward N. Brinsfield, Jr. M00052

22. Neme and Address of Facility: Brinsfield Funeral Home, P.A. P.O. Box 279, Leonardtown, MD 20650

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Entar the disaasa, or complicetions that caused ihe death. Do not enter the mode of dying, such es cardiec or raspiratory arrast, shock, or heert feilure. List only one cause on eech line.

Approximete Intervel Between Onset end Deeth

Immediate Ceuse (Finai diseesa or condition resulting in deeth)

a. Cardiac arrest — Immediate

Due to (or as a consequence of):

b. Cardiac dysrhythmia — Years

Due to (or as a consequence of):

c. Cardiomyopathy — Years

Due to (or as a consequence of):

d.

Sequentiilly iist conditions, if eny, leeding to Immedieta cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in deeth) Lest

Part Ii. **Other elgnificant conditlone** contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

23b. **Did tobacco uee contribute to the cauee of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveilebla prior to complation of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☒ Yes 2☐ No

26. Piece of Deeth (Check only one): Hospitel: 1☐ Inpatiant 2☐ ER/Outpaiient 3☒ DOA Other: 4☐ Nursing Homa 5☐ Residenca 6☐ Other (Specify)

27. Menner of Deeth: 1☐ Naturei 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Dete of injury (Month, Dey Year)

28b. Time of injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the cause(s) end menner as stated. 2☐ **Medical Examiner:** On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner stated.

29b. Signeture end title of certifier: J. Walter Valenteen MD

29c. License number: D50163

29d. Date signed (Month, Dey, Year): 5/17/97

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print): J. W Valenteen MD St. Mary's Hospital ED Leonardtown, MD 20650

State Registrar

31. Dete filed (Month, Dey, Year): MAY 21 1997

32. Registrer's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

GEORGE WILLIAM CHASE

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet tha death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attanding physician and completely filled in by the funeral director, pege 2 should be detached for use as the burial-transit

st1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17196

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Emma Mae Carr

2. Date of Death — Month: May; Day: 18; Year: 97

3. Time of Death: 1050

4a. Facility Name *(If not institution, give street and number)*: Carroll County General Hospital

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 212-01-8605

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 81 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Aug. 1, 1915

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Carroll

10c. City, Town or Location: Westminster

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1208 A. Stone Road

10f. Zip Code: 21158

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Harry J. Cashman

18. Mother's Name *(First, Middle, Maiden Surname)*: Edith Mae Slonaker

19a. Interment's Name/Relationship *(Type, Print)*: Howard E. Carr, husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1208 A. Stone Road, Westminster, MD 21158

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Meadow Branch Cemetery — Date: 05/21/97

20c. Location - City or Town, State: Westminster, MD

21. Signature of Funeral Service Licensee: ▶ Katherine Pritts-Switzer

22. Name and Address of Facility: Pritts Funeral Home & Chapel, 412 Washington Rd., Westminster, MD

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. CARDIO-PULMONARY FAILURE

Due to (or as a consequence of):
b. metastatic Ca of colon

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Ca of colon.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: None

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Professional Associates Phys. D. 20922

29c. License number

29d. Date signed *(Month, Day, Year)*: 5/19/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): 217 Washington Hts Med Center, Westminster 21157.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 21 1997

32. Registrar's Signature: Julia Lucas Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17197

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Geneva Elizabeth Crowl

2. Dete of Deeth — Month: May Dey: 15 Yeer: 1997

3. Time of Death: 12:22 AM

4e. Facility Neme (If not institution, give street end number): Collage View Center

4b. City, Town, or Location of Deeth: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 217-12-2330

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. lest birthday): 72 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Yeer): Mar 2 1925

9. Birthplace (Stete or Foreign Country): Stanley VA

Usuel Residence of Decedent

10a. Stete: MD

10b. County: Frederick

10c. City, Town or Location: Brunswick

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 508 9th Avenue

10f. Zip Code: 21716

10g. Citizen of Whet Country?: USA

11. Meritel Status: 1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Ricen, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Educetion (Specify only highest grede completed): Elementary/Secondary (0-12): 8 — College (1-4or 5+):

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Cook-Cafeteria

16b. Kind of Business/Industry: Brunswick High School

17. Fether's Neme (First, Middle, Last): Walter Lee Lucas

18. Mother's Name (First, Middle, Maiden Surneme): Vinda Lurene Burns

19a. Informant's Neme/Reletionship (Type, Print): Alan R. Crowl

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 107 East "H" St. Brunswick MD 21716

20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Plece of Disposition (Neme of cemetery, cremetory or other piece): Union Cemetery

Dete: 5/17

20c. Location - City or Town, Stete: Lovettsville VA

21. Signeture of Funerel Service Licensee: Barbara A. Williams

Barbara A. Williams, Owner

22. Neme end Address of Fecility: John T. Williams Funeral Home 100 Petersville Rd Brunswick MD 21716

Physician /Medical Examiner

23a. Pert I. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heert failure. List only one ceuse on eech line.

Approximete Interval Between Onset end Deeth

Immediete Ceuse (Finel disease or condition resulting in death): e. Pneumonia — 3 days

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leeding to immediete ceuse. Enter Underlying Cause (Diseese or Injury thet Initieted events resulting in deeth) Lest:

b.

Due to (or es a consequence of):

c.

Due to (or es e consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.: Cerebrovascular accident (stroke)

23b. Did tobacco use contribute to the causa of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Was cese referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dele end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner**: On the basis of exeminetion end/or Investigetion, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: William MD

29c. License number: 016675

29d. Date signed (Month, Dey, Yeer): 5/15/97

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): WAYNE ALCAIER, BRUNSWICK, MD 21716

State Registrar

31. Dete filed (Month, Dey, Yeer): MAY 20 1997

32. Registrar's Signeture

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Dear Ms. Tyson
the date filed
did not print out
right the 1st time
and I tried to redo
it but it didn't turn
out very well. I'm sorry
for the typos.
Thanks
Jerry

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17198

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Gary Wayne Cromwell
2. Date of Death Month Day Year: May 18, 1997
3. Time of Death: 8:29 PM
4a. Facility Name *(If not institution, give street and number)*: Frederick Memorial Hospital
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 213-64-6149
6. Sex: 1☐ M 2☐ F — X
7. Age *(In yrs. last birthday)*: 40 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 20, 1956
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5954-B Meadow Road
10f. Zip Code: 21701
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Truck Driver
16b. Kind of Business/Industry: Petroleum

17. Father's Name *(First, Middle, Last)*: William CROMWELL
18. Mother's Name *(First, Middle, Maiden Surname)*: Betty CLARK

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Barbara Cromwell, Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5954-B Meadow Road, Frederick, Maryland 21701

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mount Carmel Cemetery, Data: May 22, 1997
20c. Location - City or Town, State: Frederick, Md.

21. Signature of Funeral Service Licensee: ▶ Richard E. Gray M00255
22. Name and Address of Facility: Keeney and Basford P.A. Funeral Home, 106 East Church St., Frederick, Md. 21701

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiec or raspiretory errast, shock, or haart failura. List only one cause in each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	hypotension, Brady cardia	12 hr
Due to (or as a consequence of): b.	exercise Adeno carcinoma	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last c.	of stomach	15 mo
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number: D14C 2C
29d. Date signed *(Month, Day, Year)*: May 19, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Keough, 501 W 7th St Frederick MD 21701

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 20 1997
32. Registrar's Signature: ▶ Barbara Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17199

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Josephine Estelle Cecil
2. Date of Death Month Day Year: May 15, 1997
3. Time of Death: 3:25 AM
4a. Facility Name *(If not institution, give street and number)*: Frederick Memorial Hospital
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 217-28-5767
6. Sex: 1☐ M 2☒ F X
7. Age *(In yrs. last birthday)*: 81 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb. 28, 1916
9. Birthplace *(State or Foreign Country)*: West Virginia

Usual Residence of Decadant

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 425 Logan Street
10f. Zip Code: 21701
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use ratired)*: Supervisor
16b. Kind of Business/Industry: Clothing Factory
17. Father's Name *(First, Middle, Last)*: Larry MONTE
18. Mother's Name *(First, Middle, Maidan Surname)*: Mary MORACK
19a. Informant's Name/Relationship *(Type, Print)*: Mr. Rudell H. Cecil, Husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 425 Logan Street, Frederick, Maryland 21701
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mount Olivet Cemetery
Date: May 17, 1997
20c. Location - City or Town, State: Frederick, Maryland
21. Signature of Funeral Service Licensee: Richard E. Troy M00255
22. Name and Address of Facility: Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only ona cause on each line.

Approximeta Interval Between Onset end Deeth

Immediate Cause (Finai diseese or condition resulting in death)
a. congestive heart failure — 5 yrs.
Due to (or es a consequence of):
b. uremia
Sequentially iist conditions, if eny, leading to immediata cause. Enter Underlying Ceuse (Diseesa or injury that initieted events resulting in deeth) Lest
Due to (or es a consequence of):
c. diabetes mellitus, II
Due to (or es e consequence of):
d.

Pert ii. **Other eignificent conditions** contributing to death but not resulting in the underlying cause given in Pert i.

23b. **Did tobecco use contribute to the cause of death?** 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings eveileble prior to compietion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Deeth *(Chack only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residance 6☐ Other *(Specify)*

27. Menner of Deeth: 1☑ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)*
28b. Time of injury M
28c. injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Phyeicien:** To tha best of my knowledga, daath occurred et the tima, data and piece, and due to the causa(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceusa(s) and manner stated.

29b. Signature and title of certifier: Robert S. Hughes MD
29c. License number: D 05111
29d. Date signed *(Month, Dey, Yeer)*: 5/5/97

30. Neme end eddress of person who completed ceusa of daeth (Item 23a) (Type, Print): Dr. Robert S. Hughes MD 700 Montclaire Avenue, Frederick, Maryland 21701

State Registrar

31. Date filed *(Month, Day, Yeer)*: MAY 16 1997
32. Registrar's Signature: Julia Strickson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "naturel", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17200

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Helen M Chase

2. Date of Death: Month May Day 21 Year 1997

3. Time of Death: 1:45Am

4a. Facility Name *(If not institution, give street and number)*: Southern Maryland Hospital

4b. City, Town, or Location of Death: Clinton

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577-07-0722

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 89 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Aug 6, 1907

9. Birthplace *(State or Foreign Country)*: Willard, Va

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Suitland

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3940 Bexley Place, #211

10f. Zip Code: 20746

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Customer Service Rep.

16b. Kind of Business/Industry: Piano Mart

17. Father's Name *(First, Middle, Last)*: Frederick Willhelm Bohrer

18. Mother's Name *(First, Middle, Maiden Surname)*: Adelaide Darne

19a. Informant's Name/Relationship *(Type, Print)*: Barbara Edmonds

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3357 Jill Way , Kodak, Tenn 37764

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Cedar Hill Cemetery

Date: May 27, 1997

20c. Location - City or Town, State: Suitland, Maryland

21. Signature of Funeral Service Licensee: Reginald Ve

22. Name and Address of Facility: Lee Funeral Home, Inc 6633 Old Alexandria Ferry Rd, Clinton, Md 20735

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Metabolic Encephalopathy — ~~10~~ DAYS

Due to (or as a consequence of):

b. Cerebral Anoxia — 10 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Hypoxemia — 10 DAYS

Due to (or as a consequence of):

d. Severe Anemia — 6 MOS

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Myelodysplastic Syndrome

Upper Gastrointestinal Bleeding

Gastric Angioma

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Lucio S. Villa-Real MD

29c. License number: D 15513

29d. Date signed *(Month, Day, Year)*: 5/21/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LUCIO S. VILLA-REAL, MD - #2 ST. PATRICKS DRIVE, SUITE 502, WALDORF MD 20601

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 27 1997

32. Registrar's Signature: Julia Davidson-Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17201

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Aspacia George Coverstone

2. Date of Death Month May Dey 27, Yeer 1997

3. Time of Death: 8:00 AM

4a. Facility Name (If not institution, give street and number): 9692 Old Annapolis Road

4b. City, Town, or Location of Death: Ellicott City

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 227-22-5165

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 72 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 21, 1925

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: VA

10b. County: Frederick

10c. City, Town or Location: Stephenson

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 302 High Banks Road

10f. Zip Code: 22656

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+): 1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Medical Secretary

16b. Kind of Business/Industry: Physicians Office

17. Father's Name (First, Middle, Last): George Pete Sempeles

18. Mother's Name (First, Middle, Maiden Surname): Constance Gretes

19a. Informant's Name/Relationship (Type, Print): Lawrence P. Coverstone/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 302 High Banks Road, Stephenson, VA 22656

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Shenandoah Memorial Park

Date: 5/30/97

20c. Location - City or Town, State: Frederick Co., VA

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Omps Funeral Home 1600 Amherst St., Winchester, VA 22601

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Respiratory Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Central Nervous System Lymphoma — 1 year

Due to (or as a consequence of):

c. Non Hodgkins Lymphoma Stage IV — 8 yrs

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic anemia, Anorexia-Cachexia

Osteoporosis,

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jon K. Mumford MD

29c. License number: D 30573

29d. Date signed (Month, Day, Year): 5-27-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 11065 Little Patuxent Parkway Columbia MD 21044

State Registrar

31. Date filed (Month, Day, Year): JUN 0 9 1997

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17202

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Anna Alice Criscuolo

2. Date of Death Month / Day / Year: May 15, 1997

3. Time of Death: 4:55 pm

4a. Facility Name *(If not institution, give street and number)*: 236 Old Line Avenue

4b. City, Town, or Location of Death: Laurel

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 578-40-8519

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 11, 1914

9. Birthplace *(State or Foreign Country)*: Connecticut

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Laurel

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 236 Old Line Avenue

10f. Zip Code: 20724

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): Grade 10 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: John Powers O'Brien

18. Mother's Name *(First, Middle, Maiden Surname)*: Nellie Gertrude Condon

19a. Informant's Name/Relationship *(Type, Print)*: Constance L. Criscuolo / Daughter In Law

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 13119 Chapel Hills Drive Fredricksburg, Va. 22407

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Ft. Lincoln Cemetery

Date: 5/19/97

20c. Location - City or Town, State: Brentwood, Md.

21. Signature of Funeral Service Licensee: Guy F. Kap

22. Name and Address of Facility: Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, Maryland 20707

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Carcinoma of Lung — 4months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D00754

29d. Date signed *(Month, Day, Year)*: MAY 15, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 7525 Greenway Ctr. Dr. Greenbelt MD 20770

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 20 1997

32. Registrar's Signature: Julia Davidson Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

18

DHMH 16 Rev 6/95

97-2650-031
asp

ALEXANDER BARROW DASPIT
Items:23a part I and II,27,28a-f per MEO G-748 6/17/97

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17203

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
Alexander Barrow Daspit	MAY	13	1997	8:30 A

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
8100 CONNECTICUT AVE., #1205	CHEVY CHASE	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-44-9451	1☒ M 2☐ F	88 Yrs.			Jan. 14, 1909	Louisiana

Usual Residance of Decadant

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Chevy Chase	1☐ Yas 2☒ No

10e. Street and Number	10f. Zip Coda	10g. Citizen of Whaf Country?
8100 Connecticut Avenue, #1205	20815	United States

11. Marital Status	12. Wes Decedent Evar in U.S. Armed Forcas?	13. Was Decedenf of Hispenic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.)	14. Rece - American Indian, Black, Whita, atc.
1☐ Navar Married 2☐ Married 3☒ Widowad 4☐ Divorcad	1☐ Yes 2☒ No If Yas, Giva Yaer or Dates:	1☐ Yas 2☒ No Spacify:	Specify: white

15. Dacedant's Education (Specify only highest grada compiatad)		16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired)	16b. Kind of Business/Industry
Elamentery/Secondary (0-12)	College (1-4or 5+)		
12	5+	State Dept. Official	Foreign Service

17. Father's Neme (First, Middla, Last)	18. Mothar's Nama (First, Middla, Maiden Surneme)
Justin Daspit	Lise Sparks Barrow

19a. Informant's Name/Ralationship (Type, Print)	19b. Mailing Addrass (Street and Number or Rurel Routa Number, City or Town, Stete, Zip Coda)
Court D. Daspit	1731 Bainbridge St., Philadelphia, PA 19146

20a. Mathod of Disposition	20b. Place of Disposition (Nama of cemafary, crematory or othar place)	Data	20c. Location - City or Town, Stete
1☐ Burial 2☒ Cramation 3☐ Ramovel from Stata 4☐ Donation 5☐ Other (Specify)	Chesapeake Crematory	5-17-97	Beltsville, Maryland

21. Signature of Funaral Service Licansee	22. Nama and Addrass of Facility
▶ Ellen H. Rapp	Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complicetions that caused the deeth. Do not antar the mode of dying, such es cerdiac or raspiratory errest, shock, or haart failura. List only ona causa on eech lina.

		Approximata Intarval Batwaan Onsat and Death
Immediata Cause (Final diseasa or condition resulting in daath)	a. MIXED DRUG INTOXICATION	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, laading to immadiata ceusa. Enter Undarlying Cause (Disaasa or Injury that initiated events rasulting in daath) Last	b.	
	Dua to (or as a consequance of):	
	c.	
	Dua to (or as a consequance of):	
	d.	

Part II. **Othar significant conditions** contributing fo death but not rasulting in tha underlying cause givan in Part I.

METASTATIC PROSTATE CANCER

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Wara autopsy findings available prior to completion of ceuse of daath?
Inspection 1☐ Yes 2☒ No	1☐ Yas 2☐ No

25. Wes casa rafarrad to medical exeminar?	26. Place of Death (Check only ona)	
1☒ Yas 2☐ No	Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Homa 5☒ Residence 6☐ Othar (Specify)

27. Mannar of Daath	28a. Dete of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐ Natural 2☐ Accident 3☒ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be datarmined	5/13/97	unknown M	1☐ Yes 2☒ No	subject ingested drugs

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)	28f. Location (Straat and Number or Rural Routa Numbar, City or Town, State)
home	8100 Connecticut Ave., Chevy Chase, Md.

29a. Certifiar (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, daeth occurred at tha time, dete end place, and dua to tha ceuse(s) end mannar as steted.
2☒ **Medical Examiner:** On the basis of axamination and/or invastigation, in my opinion, daeth occurred at tha tima, data and place, and dua fo the ceusa(s) and mannar stated.

29b. Signatura end fitla of certifiar	29c. License number	29d. Data signed (Month, Day, Year)
▶ Stph S Radz, MD	O.C.M.E	MAY 14, 1997

30. Nama and address of person who completed ceusa of daath (Item 23a) (Type, Print)
Stephen S. Radentz, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed (Month, Day, Year)	32. Registrar's Signature
MAY 19 1997	▶ Jana Harrison-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17204

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARTHA A. DAVIS
2. Date of Death: Month May Day 18, Year 1997
3. Time of Death: 10:45 AM
4a. Facility Name (If not institution, give street end number): MAGNOLIA NURSING CENTER
4b. City, Town, or Location of Death: LANHAM
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 579-12-0773-D
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Year): Sept. 25, 1916
9. Birthplace (State or Foreign Country): Rocky Mount North Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince Georges
10c. City, Town or Location: Lanham Seabrook
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 8200 Good Luck Road
10f. Zip Code: 20706-3597
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Domestic
16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): Eugene Kelly
18. Mother's Name (First, Middle, Meiden Surneme): Margaret Cherry

19a. Informant's Name/Relationship (Type, Print): Susie C. Baker
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 900 G Street, N.E. #820, Washington, D.C. 20002

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Lincoln Memorial Cemetery
Date:
20c. Location - City or Town, State: Suitland, Maryland

21. Signature of Funeral Service Licensee: Larry P. Dobbins
22. Name and Address of Facility: McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W., Washington, D.C. 20012

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on eech line. — Approximete Interval Between Onset end Deeth

Immediate Cause (Final disease or condition resulting in death):
a. Cardiac arrest
Due to (or es e consequence ot):
b. severe en anemia due to Chronic Asthmbone pulmonary disease & Arterios Sclerosis
Due to (or as a consequence of):
c.
Due to (or as e consequence of):
d. severe peripheral infection of leg, arm + thrombi

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.
Cauldiac eat. Being fed NG
N.G. tube - some aspiration

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☐ No
24b. Were autopsy findings eveileble prior to completion of cause ot death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete ot Injury (Month, Dey Year): 5/18/97
28b. Time of Injury: 10:45 AM
28c. Injury at Work? 1☐ Yes 2☑ No
28d. Describe how injury occurred
28e. Piece ot Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ Certifying Phyaician: To the best ot my knowledge, deeth occurred et the time, date and placa, and due to the ceuse(s) end manner es steted. 2☐ Medical Examiner: On the basis ot examination and/or investigation, in my opinion, deeth occurred et the time, dete and place, and due to the cause(s) and manner steted.
29b. Signature and title of cartifier: Leon R Levitsky. MD
29c. License number: D09187
29d. Date signed (Month, Dey, Year): 5/19/97
30. Neme and address ot person who completed cause of deeth (Item 23e) (Type, Print): Leon R Levitsky M.D.

LEON R. LEVITSKY, M.D.
8100 GOOD LUCK ROAD SUITE 400
LANHAM, MD 20706

State Registrar

31. Dete filed (Month, Dey, Year): MAY 2 0 1997
32. Registrar's Signature: Julia Davidson-Randall

LEON R. LEVITSKY, M.D.
8100 GOOD LUCK ROAD SUITE 400
LANHAM, MD 20706

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 17205

Certificate of Death Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Helen Lewis Duncan
2. Date of Death Month: 5 Day: 18 Year: 97
3. Time of Death: 11 50 ~~AM~~
4a. Facility Name (If not institution, give street and number): Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 148-20-2943
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan 11 1916
9. Birthplace (State or Foreign Country): New Jersey

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 10325 Parkman Road,
10f. Zip Code: 20903
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Office Administrator
16b. Kind of Business/Industry: Naval Research Assoc.

17. Father's Name (First, Middle, Last): George E. Lewis
18. Mother's Name (First, Middle, Maiden Surname): Martha Schmitt

19a. Informant's Name/Relationship (Type, Print): Sandra V. Jackson
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10325 Parkman Rd., Silver Spring, Md. 20903

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Fairview Cemetery
Date: 5-21-97
20c. Location - City or Town, State: Fairview, New Jersey

21. Signature of Funeral Service Licensee: Wayne Brady
22. Name and Address of Facility: Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, Maryland 20904

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	Chronic Mitral Regurgitation	12 years
Due to (or as a consequence of): b.	Myxomatous Degeneration	years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Chronic Obstructive Lung Disease	Years
Due to (or as a consequence of): d.	Chronic Renal Insufficiency	1-2 yrs

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Acute infective Bronchitis
Congestive Heart Failure
chronic Bilateral Pleural Effusions

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Herman B Segal M.D.
29c. License number: D 25808
29d. Date signed (Month, Day, Year): 5/18/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Herman B. Segal MD 10313 Georgia Ave Silver Spring Md 20902

State Registrar

31. Date filed (Month, Day, Year): MAY 20 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17206

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY MARY JANE JANE DILLON DILLON

2. Data of Death Month: MAY Day: 18 Yeer: 1997

3. Time of Death: 6:12 PM

4a. Facility Neme (If not Institution, giva street and number): SUBURBAN HOSPITAL

4b. City, Town, or Location of Death: BETHESDA

4c. County of Deeth: MONTGOMERY

Funeral Director

5. Social Security Number: 212-20-1948

6. Sex: 1☐ M 2☒ F

7. Aga (In yrs. last birthday): 71 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Deta of Birth (Month, Dey, Year): June 3,1925

9. Birthplace (Stete or Foreign Country): Tacoma Park, MD

Usual Residanca of Decedent

10e. Steta: Delaware

10b. County: Sussex

10c. City, Town or Location: Rehoboth Beach

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 102 Sylvan Drive

10f. Zip Code: 19971

10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Nevar Married 2☒ Married 3☐ Widowad 4☐ Divorced

12. Wes Decedant Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:

13. Wes Dacedant of Hispenic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexicen, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Rece - Amarican Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elamentery/Secondery (0-12): 12

College (1-4or 5+):

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT usa ratired): Secretary

16b. Kind of Businass/Industry: Electronics Company

17. Fether's Neme (First, Middla, Last): Marcel Zimmerman

18. Mother's Name (First, Middle, Meiden Surname): Louise Cogan

19a. Informent's Nama/Ralationship (Type, Print): John Robert Dillon, Sr.

19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code): 102 Sylvan Drive, Rehoboth Beach, DE 19971

20a. Mathod of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Name of cemetery, cremetory or other piece): Eastern Shore Crematorium

Date: 05/21/97

20c. Location - City or Town, Stete: Lewes, Delaware

21. Signature of Funeral Service Licensee: S. Parsell

22. Nama end Addrass of Facility: Parsell Funeral Home & Crematorium, 1449 Kings Highway, Lewes, DE 19958

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such es cardiac or raspiratory arrast, shock, or haart failure. List only one cause on eech line.

Approximata Intarval Between Onset end Death

Immediate Ceuse (Finel disease or condition resulting in death)

a. MYOCARDIAL INFARCTION — ACUTE

Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Disaase or injury thet initiated avants resulting in death) Last

b.

Due to (or es e consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying ceuse given in Part I.

23b. Did tobacco usa contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveileble prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Wes cese referred to medicel examiner? 1☒ Yes 2☐ No

26. Piece of Deeth (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Panding investigation 6☐ Could not be datarmined

28a. Deta of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stata)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To tha best of my knowladga, daath occurred at the time, dete end piece, end dua to tha ceusa(s) and mannar as stated. 2☒ **Medical Examinar:** On tha basis of exeminetion end/or investigation, in my opinion, daath occurred at tha tima, data and piece, and due to the cause(s) end menner stated.

29b. Signature and title of certifier: [signature]

29c. Licensa number: D070994

29d. Date signed (Month, Dey, Year): MAY 19 1997

30. Nama end eddress of person who completed ceusa of daeth (Item 23a) (Type, Print): FRANCIS C MAPLE 10215 FERNWOOD RD BETHESDA MD 20817

State Registrar

31. Dete filed (Month, Dey, Year): MAY 23 1997

32. Registrar's Signeture: [signature]

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that tha death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17207

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): IRIS DUNLAP
2. Date of Death Month 5 Day 20 Year 97
3. Time of Death: 10.41 AM
4a. Facility Name (If not institution, give street and number): DORCHESTER GENERAL HOSPITAL
4b. City, Town, or Location of Death: CAMBRIDGE, MD
4c. County of Death: DORCHESTER

Funeral Director

5. Social Security Number: 266-09-7084
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 3, 1912
9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residance of Decedent

10a. State: Maryland
10b. County: Dorchester
10c. City, Town or Location: Cambridge
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 701 Radiance Drive
10f. Zip Code: 21613
10g. Citizan of Whet Country?: USA

11. Meritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, Whita, atc. Specify: White

15. Decedent's Education (Specify only highast grade completed): Elementary/Secondery (0-12): 12 College (1-4or 5+): 2
16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Domestic

17. Father's Neme (First, Middle, Last): Robert Hudson
18. Mother's Neme (First, Middle, Melden Surname): Nettie Belle Sullivan

19a. Informant's Name/Reletionship (Type, Print): John J. Carey/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 8160 Redlands St.,Apt.211, Playa del Rey,CA 90293

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from Stete 4☐ Donation 5☐ Other (Specify)
20b. Piece of Disposition (Nema of cemetary, cremetory or other place): Salisbury Crematory
Data: 5/22/97
20c. Location - City or Town, State: Salisbury, MD

21. Signature of Funeral Service Licensee: John M. Holloway
22. Name end Address of Facility: Holloway Funeral Home, 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximete Intervel Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Coronary Artery disease — not known

Due to (or as a consequence of):
b. Congestive Heart Failure. — not known

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted evants resulting in deeth) Lest
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditione contributing to death but not resulting in the underlying cause givan in Part I.: Dementia,

23b. Did tobacco use contribute to the cauee of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☐ Yas 2☒ No
24b. Were autopsy findings availeble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yas 2☒ No

26. Place of Death (Check only one)
Hospitel: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Othar (Specify)

27. Menner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending Investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year): 5-20-1997
28b. Tima of Injury: 10.41 AM
28c. Injury at Work? 1☐ Yas 2☒ No
28d. Describe how injury occurred:
28e. Piece of Injury - At homa, farm, street, factory, office building, etc. (Specify):
28f. Location (Street and Number or Rural Route Number, City or Town, Stete):

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, deeth occurred et the tima, deta end piece, and due to tha ceusa(s) and manner as stated. 2☐ Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, dete and piece, end due to the ceuse(s) and menner steted.

29b. Signeture and title of certifier: M.D
29c. License number: D-47520
29d. Deta signed (Month, Day, Year): 5/20/97

30. Name and eddress of person who completed cause of daeth (Item 23a) (Type, Print): HAMID BURNEY, 10 AURORA ST, CAMBRIDGE, MD 21613

State Registrar

31. Dete filed (Month, Day, Year): MAY 23 1997
32. Registrar's Signature: Julia Davidson Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

10

97-2421-019
wlc
LEO DIDIANGIEMO

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17208

Items:23a part I and II,27 per MEO G-748 6/17/97 dh

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Leo Anthony DiGiangiemo
2. Date of Death (Month, Day, Year): May 4, 1997
3. Time of Death: 0350a
4a. Facility Name (If not institution, give street and number): DORCHESTER GENERAL HOSPITAL
4b. City, Town, or Location of Death: CAMBRIDGE
4c. County of Death: DORCHESTER

Funeral Director

5. Social Security Number: 087-30-2182
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 63 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 9, 1933
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: New York
10b. County: Queens
10c. City, Town or Location: Queens
10d. Inside City Limits: [X] Yes 2 [ ] No
10e. Street and Number: 69-42 52nd Street
10f. Zip Code: 11431
10g. Citizen of What Country?: United States of America

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Construction Worker/ Laborer
16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Unavailable
18. Mother's Name (First, Middle, Maiden Surname): Unavailable

19a. Informent's Name/Relationship (Type, Print): Laurie Campagna - Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 36 River Street Lodi, New Jersey 07664

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Lawn Crematory
Date: 5-9-97
20c. Location - City or Town, State: Paterson, New Jersey

21. Signature of Funeral Service Licensee: Allen W. Rowe
22. Name and Address of Facility: Van Emburgh-Sneider Funeral Home, 109 Darlington Avenue Ramsey, New Jersey 07446

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury thet initiated events resulting in deeth) Lest:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.: DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medicel examiner? [X] Yes 2 [ ] No

26. Place of Deeth (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Deeth: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Dete of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dennis J. Chute, MD
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): May 6, 1997

30. Name and address of perso who completed cause of death (Item 23e) (Type, Print): Dennis J. Chute, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Day, Year): MAY 19 1997
32. Registrer's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours eftar death with the Marylend Department of Health and Mentel Hygiena.
Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 17209

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Rita Deater

2. Date of Death (Month, Day, Year): May 14, 1997

3. Time of Death: 11:50 P.M.

4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 220-26-0568

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): February 18, 1917

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 8009 Fieldstone Drive

10f. Zip Code: 21702

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elamantary/Secondary (0-12): 7 | Collaga (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cook

16b. Kind of Business/Industry: County Home

17. Father's Name (First, Middle, Last): Jonathan F. Bowers

18. Mother's Name (First, Middle, Maiden Surname): Gertrude S. Unknown

19a. Informant's Name/Relationship (Type, Print): Nancy Deater/Daughter-in-law

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8009 Fieldstone Drive, Frederick, Md. 21702

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory, or other place): Mount Olivet Cemetery | Date: May 17, 1997

20c. Location - City or Town, State: Frederick, Md.

21. Signature of Funeral Service Licensee: Richard C. L. Basford M00021

22. Name and Address of Facility: Keeney & Basford Funeral Home, 106 East Church Street, Frederick, Md. 21701

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Hepatic Coma — 1 Week
Due to (or as a consequence of):
b. Post-Necrotic Cirrhosis of Liver.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Hepatatis C
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ P. Shapiro, MD

29c. License number: D07186

29d. Date signed (Month, Day, Year): 5/16/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Philip Shapiro, M.D., 814 Toll House Ave., Frederick, Md. 21701

State Registrar

31. Date filed (Month, Day, Year): MAY 16 1997

32. Registrar's Signature

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17210

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jane Louise Dorsey
2. Date of Death: Month May Day 09, Year 1997
3. Time of Death: 10:02 PM
4a. Facility Name (If not institution, give street and number): FREDERICK MEMORIAL HOSPITAL
4b. City, Town, or Location of Death: FREDERICK
4c. County of Death: NA

Funeral Director

5. Social Security Number: 212-24-6327
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 67 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAR 10 30
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD.
10b. County: NA
10c. City, Town or Location: FREDERICK
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 10 WEST FIFTH ST
10f. Zip Code: 21701
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 TH | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DIETICIAN
16b. Kind of Business/Industry: HOSPITAL

17. Father's Name (First, Middle, Last): CHARLES BOWENS
18. Mother's Name (First, Middle, Maiden Surname): LOUISE WEEDON

19a. Informant's Name/Relationship (Type, Print): REX BOWENS GRANDSON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 817 TRAIL AVE FREDERICK, MD21701

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): RESTHAVEN MEM GAR. Date: MAY 14,97
20c. Location - City or Town, State: FREDERICK MD

21. Signature of Funeral Service Licensee: ▶ Gary L. Rollins
22. Name and Address of Facility: GARY L. ROLLINS FUNERAL HOME 21701 100 WEST ALL SAINTS ST FRDERICK MD

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. Arteriosclerotic Cardiovascular Disease — years
Due to (or as a consequence of):
b. Hypertension — years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Mitchell Rubin, M.D
29c. License number: D29591
29d. Date signed (Month, Day, Year): 5/9/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 201 Thomas Johnson Dr FREDERICK, MD 21702

State Registrar

31. Date filed (Month, Day, Year): MAY 16 1997
32. Registrar's Signature: ▶ Lisa Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17211

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Audrey DeShields

2. Date of Death: Month 5 Day 8 Year 97

3. Time of Death: 12:50 a.m.

4a. Facility Name (If not institution, give street and number): Atlantic General Hospital

4b. City, Town, or Location of Death: Berlin Md.

4c. County of Death: Worcester

Funeral Director

5. Social Security Number: 215-44-6988

6. Sex: 1 M 2 F

7. Age (In yrs. last birthday): 72 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 8-30-24

9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD

10b. County: Worcester

10c. City, Town or Location: Snow Hill, md.

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 6862 McCabe Corner Rd.

10f. Zip Code: 21863

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify:

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Domestic worker

16b. Kind of Business/Industry: House work

17. Father's Name (First, Middle, Last): Howard Corbin

18. Mother's Name (First, Middle, Maiden Surname): Olivia Ellen Harmon

19a. Informant's Name/Relationship (Type, Print): Margaret Dale

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 423 Market Street Snow Hill, Md. 21863

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. James Episcopal Church

Date: 5-13-97

20c. Location - City or Town, State: Snow Hill, Md. 21863

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: Bennie Smith Funeral Home P.O. Box 331 Pocomoke City, md. 21851

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Acute Renal Failure — 2m

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ W R Schmitt

29c. License number: D17596

29d. Date signed (Month, Day, Year): 5/8/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W R Schmitt, MD, 11220 Beauchamp Rd, Berlin, MD 21811

State Registrar

31. Date filed (Month, Day, Year): MAY 14 1997

32. Registrar's Signature: Julia [illegible] Rarbell

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17212

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Patricia Ann DUTY

2. Date of Death Month Day Year: May 18, 1997

3. Time of Death: 12:00 p.m.

4a. Facility Name *(If not institution, give street and number)*: Franklin Square Hospital Center

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-68-8973

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 45 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 9, 1952

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Joppa

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2211 Old Mountain Road Central

10f. Zip Code: 21085

10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 0 College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: NA

16b. Kind of Business/Industry: NA

17. Father's Name *(First, Middle, Last)*: Wesley James Duty

18. Mother's Name *(First, Middle, Maiden Surname)*: Virgie (NMN) Roberts

19a. Informant's Name/Relationship *(Type, Print)*: Vivian A. Duty/Sister-In-Law

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2211 Old Mountain Road Central, Joppa, MD 21085

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Bel Air Memorial Gardens

Date: 5/21/97

20c. Location - City or Town, State: Bel Air, MD

21. Signature of Funeral Service Licensee: Stephen A. Heagley

22. Name and Address of Facility: Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Cerebral edema	1 day
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	Hydrocephalus	1 day
Due to (or as a consequence of):		
c.	Subarachnoid hemorrhage	1 day
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Stuart A. Willes, M.D.

29c. License number: D06663

29d. Date signed *(Month, Day, Year)*: May 18, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Stuart Willes 9000 Franklin Square Drive Baltimore, Md. 21237

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 20 1997

32. Registrar's Signature: John Hanson Hartsell

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17213

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elizabeth Josephine DeBonis
2. Date of Death: Month May, Day 19, Year 1997
3. Time of Death: 11:30 AM
4a. Facility Name (If not institution, give street and number): 2 Lasonia Court
4b. City, Town, or Location of Death: Edgewood
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 215-14-4096
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 76 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 3, 1920
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Aberdeen
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 545 Pleasant Wind Drive
10f. Zip Code: 21001
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Joseph Marion Bolt
18. Mother's Name (First, Middle, Maiden Surname): Ava Mabel Schuler

19a. Informant's Name/Relationship (Type, Print): H. Ralph DeBonis / Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 545 Pleasant Wind Drive, Aberdeen, MD 21001

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Harford Memorial Gardens
Date: 5/22/97
20c. Location - City or Town, State: Aldino, Maryland

21. Signature of Funeral Service Licensee: ▶ Howard K. McComas III
22. Name and Address of Facility: Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Arteriosclerotic Cardiovascular Disease
Due to (or as a consequence of):
b. Hypertension
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Alzheimers Disease
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Hisup Sim MD
29c. License number: D40 412
29d. Date signed (Month, Day, Year): 5/20/97
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 319 S. Linton Ave Hanover Dr Glenn MD 21078 Hisup Sim

State Registrar

31. Date filed (Month, Day, Year): MAY 21 1997
32. Registrar's Signature: Julia Daughtery Marshall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17214

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Clifton A Douglas
2. Date of Death Month / Day / Year: May 22, 1997
3. Time of Death: 9:35 pm
4a. Facility Name *(If not institution, give street and number)*: Southern Maryland Hospital
4b. City, Town, or Location of Death: Clinton
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 212-62-1344
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 42 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: September 20, 1954
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Aquasco
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 17601 Eagle Harbor Road
10f. Zip Code: 20608
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Foreman
16b. Kind of Business/Industry: Construction

17. Father's Name *(First, Middle, Last)*: Rodney Douglas
18. Mother's Name *(First, Middle, Maiden Surname)*: Pearl Douglas

19a. Informant's Name/Relationship *(Type, Print)*: Pearl Douglas Mother
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 17601 Eagle Harbor Road Aquasco Maryland 20608

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St. Thomas Church
Date: May 28, 1997
20c. Location - City or Town, State: Brandywine, Maryland

21. Signature of Funeral Service Licensee: ▶ Lloyd M. Costello
22. Name and Address of Facility: Adams Funeral Home 20605 Aquasco Road Aquasco, 20608 Maryland

Physician /Medical Examiner

23a. Part I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. AIDS — 5 mo

Due to (or as a consequence of):
b. Pneumonia — 5 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Meningitis - Treated — 3 wks

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Thomas L Fieldson DMD
29c. License number: D01923
29d. Date signed *(Month, Day, Year)*: May 23 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): T.L. Fieldson DMD 2068 Cosmic Highway Waldorf, MD 20601

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 28 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 17215

AMENDED # 20a.P.G.C. 5-20-97cr

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Nancy T. Dubitsky

2. Date of Death: Month MAY Day 18 Year 97

3. Time of Death: 4:05pm

4a. Facility Name (If not institution, give street and number): Prince George's Hospital Ctr.

4b. City, Town, or Location of Death: Cheverly

4c. County of Death: P.G.

Funeral Director

5. Social Security Number: 120-24-8312

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 16, 1916

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Md.

10b. County: P.G.

10c. City, Town or Location: Riverdale

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 6608 Oliver St.

10f. Zip Code: 20737

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): -----

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laminator

16b. Kind of Business/Industry: Lamination

17. Father's Name (First, Middle, Last): Peter Tonschock

18. Mother's Name (First, Middle, Maiden Surname): Anna

19a. Informant's Name/Reletionship (Type, Print): Anthony S. Dubitsky (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6608 Oliver St. Riverdale, Md. 20737

20a. Method of Disposition: 1☒ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Chambers Crematory | Date: 5/24

20c. Location - City or Town, State: Riverdale, Md.

21. Signature of Funeral Service Licensee: Thomas S. Chambers

22. Name and Address of Facility: Chambers Funeral Homes, P.A. 5801 Cleveland Ave. Riverdale, Md. 20737

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

CR

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Septic Shock — 2 days

Due to (or as a consequence of):

b. Sepsis — 2 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

Due to (or as a consequence of):

c. Ischemic Bowel — 2 days

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D30318

29d. Date signed (Month, Day, Year): 5/18/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James Catavenis PGHC Crit Care Dept. Cheverly, Md. 20785

(2)

State Registrar

31. Date filed (Month, Day, Year): MAY 20 1997

32. Registrar's Signature

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17216

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: PEARLIE MAE DAVIS

2. Date of Death Month: MAY Day: 18 Year: 97

3. Time of Death: 09:15 AM

4a. Facility Name *(If not institution, give street and number)*: WASHINGTON ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: SILVER SPRING

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 578-28-2726

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: JUN 5 1916

9. Birthplace *(State or Foreign Country)*: SOUTH CAROLINA

Usual Residence of Decedent

10a. State: D.C.

10b. County:

10c. City, Town or Location: WASHINGTON

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1507 DOWNING STREET N.E.

10f. Zip Code: 20018

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 5TH; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: DOMESTIC WORKER

16b. Kind of Business/Industry: UNAVAILABLE

17. Father's Name *(First, Middle, Last)*: UNAVAILABLE

18. Mother's Name *(First, Middle, Meiden Surneme)*: GERTRUDE KNOX

19a. Informent's Name/Reletionship *(Type, Print)*: ROSA M.L. REECE-NEICE

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 10209 NEW ORCHARD DRIVE LARGO MARYLAND 20774

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Pleca of Disposition *(Neme of cemetery, cremetory or other pleca)*: LINCOLN CEMETERY Dete: MAY 24 97

20c. Location - City or Town, State: SUITLAND ,MD

21. Signeture of Funeral Service Licensee: W.H. Bacon 276

22. Name and Address of Facility: W.H. BACON FUNERAL HOME INC. 3447 14TH STREET,N.W. WASH,D.C. 20010

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart feilure. List only one ceuse on eech line.

Approximete Interval Between Onset and Death

Immedlete Ceuse (Flnel diseese or condition resulting in deeth) e. BOWEL INFARCT — 3 Days

Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in death) Lest

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings availeble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Plece of Deeth *(Check only one)*: Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, fectory, offica building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Phyeician:** To the best of my knowledge, deeth occurred et the time, dete end placa, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) end manner steted.

29b. Signeture and title of certifier: JR

29c. License number: 20391

29d. Date signed *(Month, Dey, Year)*: MAY, 18, 1997

30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print): JR JEFFREY KELMAN, 6525 BELCREST ROAD, HYATTSVILLE, MD 20782

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State Registrar

31. Dete filed *(Month, Day, Year)*: MAY 22 1997

32. Registrer's Signeture: Gladys Hendrson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17217

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: GEORGE ARMSTRONG DORNIN, JR.

2. Date of Death: Month May Day 03 Year 1997

3. Time of Death: 9:15a.m.

4a. Facility Name *(If not institution, give street and number)*: St. Mary's Hospital

4b. City, Town, or Location of Death: Leonardtown

4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 213-07-3460

6. Sex: 1■ M 2☐ F

7. Age *(In yrs. last birthday)*: 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: August 23,1911

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: St. Mary's

10c. City, Town or Location: Lexington Park

10d. Inside City Limits: 1☐ Yes 2■ No

10e. Street and Number: 23630 Town Creek Drive

10f. Zip Code: 20653

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2■ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2■ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2■ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Engineer

16b. Kind of Business/Industry: Steel Industry

17. Father's Name *(First, Middle, Last)*: George Armstrong Dornin, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Florence Lesesne Tait

19a. Informant's Name/Relationship *(Type, Print)*: Jean Allen Dornin, Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 23630 Town Creek Drive, Lexington Park, Maryland 20653

20a. Method of Disposition: 1☐ Burial 2■ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory

Date: 5-5-1997

20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Edward N. Brinsfield, Jr., M00052

22. Name and Address of Facility: Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, Maryland 20650-0279

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure — one month

Due to (or as a consequence of):

b. COPD. / Aspiration — 1-2 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: GI bleeding., Dementia.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1■ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Zahir Yousaf

29c. License number: D27189

29d. Date signed *(Month, Day, Year)*: May 05, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Zahir Yousaf Huntingtown MD. 20639

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 05 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 17218

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Milton Wendell Dickens

2. Data of Daath Month / Dey / Yeer: MAy 24, 1997

3. Tima of Deeth: 11:20a.m.

4a. Facility Name (If not institution, give straat and number): St. Mary's Hospital

4b. City, Town, or Location of Deeth: Leonardtown

4c. County of Deeth: St. Mary's

Funeral Director

5. Social Security Numbar: 577-18-8913

6. Sex: 1■ M 2☐ F

7. Aga (In yrs. last birthday): 90 Yrs.

If Under 1 Yaar: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): May 24, 1907

9. Birthplaca (State or Foreign Country): Maryland

Usual Rasidance of Decedant

10a. Stata: Maryland

10b. County: Prince George's

10c. City, Town or Location: Fort Washington

10d. Insida City Limits: 1☐ Yas 2■ No

10e. Street end Number: 6220 Dimrill Court

10f. Zip Coda: 20744

10g. Citizan of Whet Country?: United States

11. Marital Status: 1☐ Naver Married 2■ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yes 2■ No If Yas, Giva Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 1☐ Yas 2■ No Specify:

14. Rece - American Indian, Bleck, White, atc. Specify: Black

15. Decedant's Education (Specify only highest grada complated): Elamentery/Secondary (0-12): 6 / College (1-4or 5+):

16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired): Waterman

16b. Kind of Businass/Industry: Fishing Industry

17. Fathar's Nama (First, Middla, Last): Henry Dickens

18. Mothar's Nama (First, Middla, Maidan Surnama): Elizabeth Blackwell

19a. Informant's Name/Ralationship (Type, Print): Joyce T. Larkins, Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code): 6220 Dimrill Court, Fort Washington, Maryland 20744

20a. Mathod of Disposition: 1■ Buriel 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Spacify)

20b. Placa of Disposition (Nama of cematary, cramatory or othar place): St. George Church Cemetery

Data: 5-30-97

20c. Location - City or Town, Stete: Valley Lee, Maryland

21. Signature, Funeral Service Licensee: Edward N. Brinsfield, Jr., M00052

22. Nama and Address of Facility: Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, Maryland 20650-0279

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Entar tha disease, or complicetions thet caused the death. Do not entar tha mode of dying, such as cerdiec or raspiratory arrest, shock, or heart failura. List only ona causa on aach lina.

Approximata Intarval Batween Onset and Deeth

Immadiata Ceusa (Final diseasa or condition resulting in daeth):
a. aspiration, acute respiratory insufficiency — 5 minutes
Due to (or as a consequence of):
b. post-op left above knee amputation — 48 hrs
Due to (or as a consequence of):
c. gangrene left lower leg — months
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immadiate ceuse. Entar Underlying Cause (Diseesa or injury thet initieted events resulting in daath) Last

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying ceusa givan in Part i.

23b. Did tobecco use contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was en eutopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to compiation of causa of death? 1☐ Yas 2☐ No

25. Was casa rafarred to medical examinar? 1☐ Yes 2☐ No

26. Piece of Deeth (Check only one): Hospital: 1☐ Inpatiant 2☐ ER/Outpetient 3☐ DOA Othar: 4☐ Nursing Homa 5☐ Residence 6☐ Other (Specify)

27. Mennar of Death: 1☐ Neturel 2☐ Accidant 3☐ Sulcida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarminad

28a. Dete of Injury (Month, Day Yaar)

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify)

28f. Location (Streat and Number or Rural Route Number, City or Town, Stata)

Medical Certification: To Be Completed by Physician/Medical Examiner

NAME: MILTON WENDELL DICKENS
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requiras that the death certificata be executed within 24 hours aftar death.
To the Funeral Director: After this certificate has been signed by the attending physician and completaly filled in by the funeral director, paga 2 should be detached for use as the buriel-transit

29a. Cartifier (Check only one): 1☐ **Cartifying Physician:** To tha bast of my knowledga, deeth occurred at tha time, date end place, and dua to the cause(s) and manner as steted. 2☐ **Medical Examinar:** On tha basis of examination and/or invastigation, in my opinion, daath occurred at the tima, data and piece, end dua to tha causa(s) end mannar stated.

29b. Signature end titla of certifier

29c. Licensa number: D29821

29d. Dete signed (Month, Day, Yaar): 5/27/97

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): 650 MOAKLEY ST. LEONARDTOWN, MD 20650 James L. Damalouji, M.D.

State Registrar

31. Data filed (Month, Day, Yaar): MAY 30 1997

32. Registrar's Signetura: Julia Strickson Randall

DHMH 16 Rav 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17219

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Aura Iola Deneen

2. Date of Death Month Day Year: May 26, 1997

3. Time of Death: 10:30 PM

4a. Facility Name (If not institution, give street and number): Avalon Manor Nursing Home

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 174-20-1965

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 89 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jul. 16, 1907

9. Birthplace (State or Foreign Country): Penna.

Usual Residence of Decedent

10a. State: Pa.

10b. County: Fulton

10c. City, Town or Location: Warfordsburg

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: P.O. Box 29

10f. Zip Code: 17267

10g. Citizen of What Country? USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher

16b. Kind of Business/Industry: Education

17. Father's Name (First, Middle, Last): Scott O Deneen

18. Mother's Name (First, Middle, Maiden Surname): Lillian Fisher

19a. Informant's Name/Relationship (Type, Print): Scott Dorfman/ Nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): Kalamazoo, Mi. 49001

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Cem Warfordsburg Presby

Date: 5/30

20c. Location - City or Town, State: Warfordsburg, Pa.

21. Signature of Funeral Service Licensee: Donald C. Burner

22. Name and Address of Facility: Burner Trade Services 1037 Dual Pl. Hagerstown, Md. 21740

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Sepsis — two days

Due to (or as a consequence of):
b. Cerm of unknown origin — 2 wks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypertension Diabetes Mellitus Bilateral Cerebro vascular Accident Hyperlipidemia Cardiovascular Disease Chronic Renal insufficiency

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D18019

29d. Date signed (Month, Day, Year): May 27, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Vasant Datta M.D. 334 Mill St. Hagerstown, Md. 21740

State Registrar

31. Date filed (Month, Day, Year): MAY 28 1997

32. Registrar's Signature: Julie Bruchon Rockell

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

97 17220

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): James Robert DeMont		2. DATE OF DEATH (Month, Day, Year): May 19 1997	3. TIME OF DEATH: 2:25 pm
4. SOCIAL SECURITY NUMBER: 145-10-1018	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 82 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 3/19/15
8. BIRTHPLACE (State or Foreign Country): New Jersey			
9a. FACILITY NAME (If not institution, give street and number): Long View Nursing Home	9b. CITY, TOWN OR LOCATION OF DEATH: Manchester	9c. COUNTY OF DEATH: Carroll	

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Carroll	10c. CITY, TOWN OR LOCATION: Westminster	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 510 Pinehurst Circle		10f. ZIP CODE: 21157	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WWII	13. WAS DECENDENT OF HISPANIC DRIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Supervisor	16b. KIND OF BUSINESS/INDUSTRY: Fish Hatchery	
17. FATHER'S NAME (First, Middle, Last): John DeMont		18. MOTHER'S NAME (First, Middle, Maiden Surname): Catherine McDermott	
19a. INFORMANT'S NAME (Type/Print): Robert DeMont/son	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1906 Shetland Rd. Finksburg MD 21048		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) DATE: Meadow Branch Cemetery 5/22/97	20c. LOCATION — City or Town, State: Westminster	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert A Myers	22. NAME AND ADDRESS OF FACILITY: 91 Willis Street Myers Funeral Home Westminster, MD 21157		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CVA	48hr
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (DR AS A CONSEQUENCE OF): b. ASCVD	5yr
	DUE TO (OR AS A CONSEQUENCE OF): c.	
	DUE TO (OR AS A CONSEQUENCE OF): d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: [X] 1 Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year): N/A	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28d. DESCRIBE HOW INJURY OCCURED	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29e. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: John Middleton	29c. LICENSE NUMBER: D25443	29d. DATE SIGNED (Month, Day, Year): ▶ 5/20/97

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 68 Prole Road Westminster Md 21157 21157

31. DATE FILED (Month, Day, Year): MAY 20 1997	32. REGISTRAR'S SIGNATURE: Julia Mathew Randall

DHMH-16 Rev 1/88

97 17221

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mildred Viola Donaldson					2. DATE OF DEATH (Month, Day, Year): May 27, 1997	3. TIME OF DEATH: 12:30 p.m.
4. SOCIAL SECURITY NUMBER: 214-16-0383	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 92 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): April 27, 1905	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Clearview Nursing Home			9b. CITY, TOWN OR LOCATION OF DEATH: Hagerstown			9c. COUNTY OF DEATH: Washington
RESIDENCE OF DECEDENT						
10a. STATE: Maryland	10b. COUNTY: Washington	10c. CITY, TOWN OR LOCATION: Hagerstown				10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1229 Salem Avenue			10f. ZIP CODE: 21740			10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 5 / College (1-4 or 5+): 0	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): homemaker	16b. KIND OF BUSINESS/INDUSTRY: her own home				
17. FATHER'S NAME (First, Middle, Last): Monroe Light	18. MOTHER'S NAME (First, Middle, Maiden Surname): Lilly Everhart					
19a. INFORMANT'S NAME (Type/Print): D. Winifred Zimmerman - daughter	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14608 National Pike, Clear Spring, Md. 21722					
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Lawn Memorial Park	DATE: 5-29-97	20c. LOCATION — City or Town, State: Hagerstown, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Scott Minnich	22. NAME AND ADDRESS OF FACILITY: MINNICH FUNERAL HOME 415 E.Wilson Blvd., Hagerstown, Md. 21740					

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute bronchopneumonia	3 days
DUE TO (OR AS A CONSEQUENCE OF):	b. Debydration	2 week
DUE TO (OR AS A CONSEQUENCE OF):	c. Starvation	2 week
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	d. Dementia of Alzheimers type	4 years

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Parkinsons Disease, old cerebral infarction
Hypertensive cardiovascular Disease

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☑ NO	1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☑

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☑ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)			
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Edson Moody	005787	5/27/1997

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
1190 Mt. AETNA RD HAGERSTOWN, MARYLAND EDSON B. MOODY

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
MAY 29 1997	Julia Hudson Rader

DHMH-16 Rev 1/89

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17222

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Lewis Henry DELLINGER

2. Date of Death Month / Day / Yaar: May 24 1997

3. Time of Death: 8:20 P.m.

4a. Facility Name *(If not institution, give street and number)*: Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 215-20-7996

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 86 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec. 22, 1910

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: ☒ Yas 2☐ No

10e. Straet and Number: 1176 Luther Drive

10f. Zip Code: 21740

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yas, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Educetion *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 0-8; College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Giva kind of work done during most of working life. DO NOT usa ratired)*: salesman

16b. Kind of Business/Industry: automobile

17. Father's Name *(First, Middle, Last)*: Henry Dellinger

18. Mothar's Name *(First, Middla, Maiden Surname)*: Mary Susan Rhodes

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Elinor S. Dellinger/wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stata, Zip Code)*: 1176 Luther Drive, Hagerstown, Maryland 21740

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Ramoval from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Rest Haven Cemetery

Date: May 29, 1997

20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Scott M Minnich

22. Name and Address of Facility: Minnich Funeral Home 445 East Wilson Blvd., Hagerstown, Maryland 21740

Physician /Medical Examiner

23a. Part1. Enter the disaase, or complications that causad the death. Do not enter the moda of dying, such as cerdiac or respiratory arrast, shock, or heart failure. List only one cause on each line.

Approximata Intarval Between Onset and Death

Immadiata Cause (Final diseasa or condition resulting in death)

a. Acute Respiratory Failure — 1 day

Due to (or as a consaquence of):

b. Congestive Heart Failure — 6 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequenca of):

d.

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying cause givan in Part I.

23b. Did tobacco use contribute to the causa of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to compiation of ceuse of daath? 1☐ Yes 2☐ No

25. Was cesa rafarred to medicel examiner? 1☐ Yas 2☑ No

26. Place of Death *(Check only ona)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Othar *(Specify)*

27. Manner of Daath: 1☑ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At homa, farm, street, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Phyaician:** To tha best of my knowledga, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurrad at tha tima, data and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Michael J. McCormack MD

29c. Licensa number: 041667

29d. Date signed *(Month, Day, Year)*: 5/25/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael McCormack 11110 Medical Campus Suite 130 Hagerstown, MD 21742

State Registrar

31. Data filed *(Month, Day, Year)*: MAY 2 7 1997

32. Registrar's Signature: Julia Anderson Bailey

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Dellinger, Lewis Henry

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17223

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ETHEL MAE DIXON

2. Date of Death: Month: May; Day: 22; Year: 1997

3. Time of Death: 2053

4a. Facility Name *(If not institution, give street and number)*: Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 224-54-3813

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 62 Yrs.

If Under 1 Year: Months; Days

If Under 24 Hrs.: Hours; Min.

8. Date of Birth *(Month, Day, Year)*: Jan. 24, 1935

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 11214 Youngstoun Drive

10f. Zip Code: 21742

10g. Citizen of What Country?: USA

11. Maritel Status: 1☒ Navar Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yas, Give Yeer or Datas:

13. Was Decedent of Hispenic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexicen, Puerto Rican, atc.): 1☐ Yas 2☒ No *Specify:*

14. Race - Americen Indian, Bleck, Whita, atc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 3; Collega (1-4or 5+): 0

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Home Health Care Aid

16b. Kind of Business/Industry: Self Employed

17. Fether's Neme *(First, Middle, Last)*: Harry Lee Dixon

18. Mother's Nema *(First, Middle, Maiden Surname)*: Susie Viola Speaks

19a. Informent's Neme/Reietionship *(Type, Print)*: Roger H. Dixon, Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 11214 Youngstoun Drive, Hagerstown, Maryland 21742

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Name of cemetery, crematory or other place)*: Hillsboro Cemetery

Dete: May 27

20c. Location - City or Town, Stete: Hillsboro, Virginia

21. Signeture of Funeral Service Licensee: Kelly A. Dourke

22. Name and Address of Facility: Douglas A. Fiery Funeral Home, 1331 Eastern Blvd. N., Hagerstown, Maryland 21742

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Carcinoma Lung — Months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was cese referred to medical examiner? 1☐ Yes 2☑ No

26. Piece of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Naturel 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Deta of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Placa of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. Licensa number: D41827

29d. Date signed *(Month, Day, Year)*: 5/24/97

30. Neme end eddress of person who completed ceuse of death (Item 23a) (Type, Print): J. Alencherry MD 12821 Oak hill ave, Hagerstown MD 21740

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Ethel Mae Dixon

State Registrar

31. Dete filed *(Month, Day, Year)*: MAY 27 1997

32. Registrer's Signeture

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17224

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Albert William Dawkins

2. Date of Death — Month: May; Day: 19; Year: 1997

3. Time of Death: 15:42

4a. Facility Name *(If not institution, give street and number)*: 517 Round Top Road (At Home)

4b. City, Town, or Location of Death: Chestertown

4c. County of Death: Queen Anne's

Funeral Director

5. Social Security Number: 218-34-8614

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 60 Yrs.

If Under 1 Year — Months: ; Days:

If Under 24 Hrs. — Hours: ; Min.:

8. Date of Birth *(Month, Day, Year)*: October 4, 1936

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedant

10a. State: Maryland

10b. County: Queen Anne's

10c. City, Town or Location: Chestertown

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 517 Roundtop Road

10f. Zip Code: 21620

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No — If Yes, Give Year or Dates: 1960-1963

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Carpenter

16b. Kind of Business/Industry: Construction

17. Father's Name *(First, Middle, Last)*: Charles Dawkins

18. Mother's Name *(First, Middle, Maiden Surname)*: Hilda Miles

19a. Informant's Name/Relationship *(Type, Print)*: Barbara Dawkins/Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 517 Roundtop Road, Chestertown, Maryland 21620

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, cremetory or other place)*: Chester Cemetery/May 22, 1997

20c. Location - City or Town, State: Chestertown, Maryland

21. Signature of Funeral Service Licensee: Kirk L. Helfenbein

22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardiopulmonary Arrest

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Arteriosclerotic Hypertensive Cardiovascular Disease

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Type II Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

28. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☒ Residance 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*: None

28b. Time of injury: M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of Certifier: John L. Bowerman Jr. M.D

29c. License number: 023889

29d. Data signed *(Month, Day, Year)*: 5/20/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John L. Bowerman Jr. M.D 944 Washington Ave, Chestertown Md 21620

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 21 '97

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17225

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MELVIN LEROY DIXON
2. Date of Death Month / Day / Year: MAY 19 1997
3. Time of Death: 0635
4a. Facility Name *(If not institution, give street and number)*: Memorial Hospital
4b. City, Town, or Location of Death: CUMBERLAND, MD
4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 213-44-1772
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 53 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Oct 8, 1943
9. Birthplace *(State or Foreign Country)*: WV

Usual Residence of Decedent

10a. State: MD
10b. County: Allegany
10c. City, Town or Location: Rawlings
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: P.O. Box 148
10f. Zip Code: 21557
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: retired
16b. Kind of Business/Industry: CSX Railroad

17. Father's Name *(First, Middle, Last)*: William Lee Dixon
18. Mother's Name *(First, Middle, Maiden Surname)*: Carrie Belle (Kuykendall)

19a. Informant's Name/Relationship *(Type, Print)*: Theresa L. Dixon-wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P.O. Box 148 Rawlings MD 21557

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Cumberland Crematory
Date: 05/22
20c. Location - City or Town, State: Cumberland, MD

21. Signature of Funeral Service Licensee: Nicholas J Scarpelli
22. Name and Address of Facility: Scarpelli Funeral Home Cumberland, MD 21502

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. PROBABLE ACUTE MYOCARDIAL INFARCTION — 1/2 hour

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death *(Check only one)*: Hospital: 1 ☐ inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D33280
29d. Date signed *(Month, Day, Year)*: May 20, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): DR. SUNIL GUPTA JOHNSON HEIGHTS MEDICAL BUILDING CUMBERLAND, MD 21502

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 21 1997
32. Registrar's Signature:

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10
yes

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17226

DEAN DOROTHY

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last): Dorothy Lois Dean
2. Date of Death (Month, Day, Year): May 24, 1997
3. Time of Death: 12:30 AM
4a. Facility Name (If not institution, give street and number): Prince George's Medical Center
4b. City, Town, or Location of Death: Cheverly
4c. County of Death: Prince George's
5. Social Security Number: 577-38-8450
6. Sex: 1☐ M 2☐ F XX
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct 17, 1914
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Calvert
10c. City, Town or Location: Dunkirk
10d. Inside City Limits: 1☐ Yes 2☒ No XX
10e. Street and Number: 1441 Knight Ave
10f. Zip Code: 20754
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed X 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No X If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No X Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Office Manager
16b. Kind of Business/Industry: Music
17. Father's Name (First, Middle, Last): Shirley Eugene Belcher
18. Mother's Name (First, Middle, Maiden Surname): Annie Lois Chappell
19a. Informant's Name/Relationship (Type, Print): Leo Phillips
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1441 Knight Ave, Dunkirk, Maryland 20754
20a. Method of Disposition: 1☒ Burial XX 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Fort Lincoln Cemetery | Date: May 27, 1997
20c. Location - City or Town, State: Brentwood, Maryland
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Lee Funeral Home, Inc 6633 Old Alexandria Ferry Rd, Clinton, Md 20735

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia
Due to (or as a consequence of):
b. Sepsis
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Coronary artery disease
Due to (or as a consequence of):
d. congestive heart failure

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No
25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year): 5
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D43662
29d. Date signed (Month, Day, Year): 5/24/97
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. W. Boyce PGHC Critical Care Cheverly MD 20785

State Registrar

31. Date filed (Month, Day, Year): MAY 27 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17227

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Elizabeth Lundquist Dahlberg

2. Dete of Deeth: Month May, Dey 20, Yeer 1997

3. Time of Death: 10:37 am

4e. Fecility Neme (If not Institution, give street and number): Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Deeth: Frederick

Funeral Director

5. Social Security Number: 067-12-7463

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthdey): 79 Yrs. | If Under 1 Year: Months, Deys | If Under 24 Hrs.: Hours, Min.

8. Dete of Birth (Month, Day, Year): April 2, 1918

9. Birthplece (Stete or Foreign Country): New York

Usuel Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 2395 Bear Den Road

10f. Zip Code: 21701

10g. Citizen of Whet Country?: U.S.A.

11. Meritel Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12); College (1-4or 5+): 4

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Consulting Radio Engineer

16b. Kind of Business/Industry: Lohnes & Culver

17. Fether's Name (First, Middle, Last): Otto William Lundquist

18. Mother's Name (First, Middle, Maiden Surneme): Eleanor Van Twisk

19a. Informant's Neme/Reletionship (Type, Print): Gustav I. Dahlberg/Husband

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 2395 Bear Den Road, Frederick, Maryland 21701

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Placa of Disposition (Neme of cemetery, cremetory or other piece): Resthaven Mem. Gardens

Date: 5/24

20c. Location - City or Town, Stete: Frederick, Maryland

21. Signeture of Funerel Service Licensee: Robert E. Dailey Jr

22. Neme end Address of Fecility: ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure - list only one cause on each line.

		Approximete Interval Between Onset end Death
Immediete Cause (Finel disease or condition resulting in death) e.	Cerebrovascular accident	few hou
Due to (or es e consequence of):		
Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Lest b.	coronary artery disease	few yrs.
Due to (or es e consequence of):		
c.		
Due to (or es e consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Atrial fibrillation Part cerebrovascular accident

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings eveileble prior to completion of cause of death? NA 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Menner of Death: 1☑ Neturel 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Year): NA

28b. Time of Injury: M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner**: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, date end plece, end due to the ceuse(s) end menner stated.

29b. Signeture end title of certifier: MD

29c. License number: D 18063

29d. Date signed (Month, Day, Yeer): 5/21/97.

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print): ABDUL MAJEED 801 TOLLHOUSE AVE. FREDERICK MD 21701

State Registrar

31. Dete filed (Month, Day, Year): MAY 28 1997

32. Registrar's Signeture: Julia Sheridan-Randall

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17228

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): TEDDY DUNCAN
2. Date of Death (Month, Day, Year): MAY 16 1997
3. Time of Death: 8:15AM
4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL CENTER
4b. City, Town, or Location of Death: RANDALLSTOWN
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 216-44-5304
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 57 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb 4, 1940
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Owings Mill
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: Rosewood Center, Rosewood Lane
10f. Zip Code: 21117
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): Grade 1 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Lawn Maintenance
16b. Kind of Business/Industry: Cemetery

17. Father's Name (First, Middle, Last): Theodore Duncan
18. Mother's Name (First, Middle, Maiden Surname): Louise Evelyn Bruner

19a. Informant's Name/Relationship (Type, Print): Louise Duncan mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 647 E. Maple, McConnellsberg, Pennsylvania 17233

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Meadowridge Memorial Park
Date: 5/19
20c. Location - City or Town, State: Dorsey, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Donaldson Funeral Home, P.A.
313 Talbott Ave. Laurel, Maryland 20707-4389

Physician /Medical Examiner

23a. Part1. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causa on aach line.

		Approximate Interval Between Onset and Death
Immediate Causa (Final disease or condition resulting in death) a.	RESPITORY FAILURE	5DAYS
Due to (or as a consequenca of): b.	PNEUMONIA	2 WEEKS
Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Causa (Disaase or injury that initiatad avants resulting in death) Last. Due to (or as a consequenca of): c.	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	YEARS
d.		

Part II. **Other signifficant conditiona** contributing to death but not resulting in the underlying causa givan in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to madical examinar? 1☐ Yas 2☑ No

26. Place of Death (Check only ona): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending invastigation 6☐ Could not be detarminad

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Dascribe how injury occurred
28e. Placa of Injury - At home, farm, streat, factory, office building, etc. (Specify)
28f. Location (Straat and Number or Rural Route Number, City or Town, Stata)

29a. Certifiar (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at tha tima, data and placa, and due to the cause(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of examination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and due to the cause(s) and mannar stated.

29b. Signature and title of certifier: ▶ [signature] K.S.RAO.M.D.
29c. License number: D43462
29d. Date signed (Month, Day, Year): MAY 16 1997

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): K.S.RAO.M.D.
NORTHWEST HOSPITAL CENTER, RANDALLSTOWN. MD

State Registrar

31. Data filed (Month, Day, Year): MAY 20 1997
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17229

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edmond A. DeHaven

2. Date of Death: Month: May; Day: 14; Year: 1997

3. Time of Death: 23 00

4a. Facility Name (If not institution, give street and number): St. Agnes Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: None

Funeral Director

5. Social Security Number: 214-09-7785

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 88 Yrs.

If Under 1 Year: Months: ; Days:

If Under 24 Hrs.: Hours: ; Min.:

8. Date of Birth (Month, Day, Year): May 4, 1909

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Marriottsville

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 11820 Route 99

10f. Zip Code: 21104

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): unknown; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Steel Worker

16b. Kind of Business/Industry: Steel Manufacturer

17. Father's Name (First, Middle, Last): Stewart DeHaven

18. Mother's Name (First, Middle, Maiden Surname): Annie PARKINSON

19a. Informant's Name/Relationship (Type, Print): Norma Mae DeHaven/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11820 Route 99 Marriottsville, Maryland 21104

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. View Cemetery

Date: 5-19-97

20c. Location - City or Town, State: Marriottsville, MD

21. Signature of Funeral Service Licensee: ▶ Glenn A. Collins - Witzke

22. Name and Address of Facility: Harry H. Witzke Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Renal failure — 1 month

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

SEPSIS, Cancer Porta HEPATIS, Biliary obstruction, Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) end manner es steted. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier: ▶ Orlando Hernandez, MD

29c. License number: D46704

29d. Date signed (Month, Dey, Year): MAY 14, 1997

30. Neme and address of person who completed cause of death (Item 23e) (Type, Print): MUTOMBO KAPONDE, STAGNES HOSPITAL, BLT, MD

State Registrar

31. Dete filed (Month, Day, Year): MAY 19 1997

32. Registrer's Signature: Julia Davidson Rudolph

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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97 17230

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEOENT'S NAME (First, Middle, Last): MORRIS H. EPSTEIN			2. DATE OF DEATH (Month, Day, Year): mAY 20, 1997	3. TIME OF OEATH: 1:47A M
4. SOCIAL SECURITY NUMBER: 578-20-9824	5. SEX: 1 X M 2 ☐ F	6. AGE (In yrs. last birthday): 82 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Sep. 13, 1914	8. BIRTHPLACE (State or Foreign Country): Wash. DC
9a. FACILITY NAME (If not institution, give street and number): Hebrew Home of Greater Washington		9b. CITY, TOWN OR LOCATION OF DEATH: Rockville		9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Rockville	10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO
10e. STREET AND NUMBER: 6121 Montrose Rd.		10f. ZIP CODE: 20852	10g. CITIZEN OF WHAT COUNTRY?: US

11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+): 2	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerk	16b. KIND OF BUSINESS/INDUSTRY: Liquor Store	
17. FATHER'S NAME (First, Middle, Last): Louis Epstein		18. MOTHER'S NAME (First, Middle, Maiden Surname): Rebecca Rabinowitz	
19a. INFORMANT'S NAME (Type/Print): Dorothy Epstein/ Wife	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4450 South Park Ave. Chevy Chase, Md. 20815		
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Neme of cemetery, crematory or other piece): Mt. Lebanon cemetery DATE: 5/22/97	20c. LOCATION — City or Town, State: Adelphi, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶	22. NAME AND ADDRESS OF FACILITY: Edward Sagel Funeral Direction 1091 Rockville Pike Rockville, Md. 20852		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter tha mode of dying, such ea cerdiec or reapiratory arreat, ahock, or heart failure. Liet only one ceuse on each iine.

		Approximeta interval Between Onset and Death
IMMEDIATE CAUSE (Finel disease or condition resulting in death) →	a. SEPTIC SHOCK	1 WEEK
	OUE TO (OR AS A CONSEQUENCE OF): —	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST	b.	
	OUE TO (OR AS A CONSEQUENCE OF): —	
	c.	
	OUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: INSULIN-DEPENDENT DIABETES MELLITUS

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO X UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
MD Attending Physician	D 18084	▶ MAY 20, 1997

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print): D. D. PATEL M.D. 6121 MONTROSE RD, ROCKVILLE, MD 20852

31. DATE FILED (Month, Day, Year)	32. REGISTRARS SIGNATURE
MAY 23 1997	Julia Davidson-Randall

DHMH-16 Rev 1/89

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17231

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Howard B. Elliott, II

2. Date of Death Month: MAY Day: 23 Year: 1997

3. Time of Death: 1204

4a. Facility Name *(If not institution, give street and number)*: PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 217-54-7223

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 47 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 9, 1950

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10e. State: MD

10b. County: Wicomico

10c. City, Town or Location: Salisbury

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 120 Greenmount Ave.

10f. Zip Code: 21804

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): / College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Plumbing & Heating Contractor

16b. Kind of Business/Industry: Self Employed

17. Father's Name *(First, Middle, Last)*: Howard B. Elliott

18. Mother's Name *(First, Middle, Maiden Surname)*: Nellie M. Gordy

19e. Informant's Name/Relationship *(Type, Print)*: Howard B. Elliott - Father

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 120 Greenmount Ave. Salisbury, MD 21804

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, cramatory or other place)*: Wicomico Memorial Park

Date: 5-27-97

20c. Location - City or Town, State: Salisbury, MD

21. Signature of Funeral Service Licensee: Gerald C Bounds

22. Name and Address of Facility: Bounds Funeral Home, 705 E. Main St. Salisbury, MD 21804

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Howard Elliott 217-54-7223

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2 Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction — minute

Due to (or as a consequence of):

b. Severe Coronary Artery Disease — Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dilated Ischemic Cardiomyopathy

Pulmonary Hypertension

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Joseph Crooke MD

29c. License number: D44069

29d. Date signed *(Month, Day, Year)*: 5.23.97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Joseph Crooke 106 Milford St #104 Salisbury MD 21804

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 27 1997

32. Registrar's Signature: Julia Davidson Randall

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17232

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Karl H. Endlich

2. Date of Death Month Day Year: May 25, 1997

3. Time of Death: 1:35 a.m.

4a. Facility Name (If not institution, give street and number): Edw.W.McCready Memorial Hospital

4b. City, Town, or Location of Death: Crisfield

4c. County of Death: Somerset

Funeral Director

5. Social Security Number: 213-18-1954

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 77 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 2, 1919

9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Somerset

10c. City, Town or Location: Manokin

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 8711 Hood Road

10f. Zip Code: 21836

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No. If Yes, Give Year or Dates: World War II

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4or 5+): 2

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Machinist

16b. Kind of Business/Industry: Marine

17. Father's Name (First, Middle, Last): Philip Endlich

18. Mother's Name (First, Middle, Maiden Surname): Minnie Meibohm

19a. Informant's Name/Relationship (Type, Print): Margaret M. Endlich (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8711 Hood Rd. - P.O. Box 6 - Manokin, MD 21836

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. Paul's Cemetery

Date: 5/27/97

20c. Location - City or Town, State: Marion Station, MD

21. Signature of Funeral Service Licensee: Robert H. Bradshaw

22. Name and Address of Facility: Bradshaw & Sons Funeral Home, 306 W. Main St. - Crisfield, MD 21817

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARDIAC ARRHYTMIA — MINUTES

Due to (or as a consequence of):

b. ACUTE MYOCARDIAL INFARCTION — DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ALZHEIMER'S DISEASE

HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D48002

29d. Date signed (Month, Day, Year): 05/25/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): OLUSEGUN OGUNFOWORA, McCready Memorial Hospital, Crisfield, MD

State Registrar

31. Date filed (Month, Day, Year): MAY 28 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17233

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Inez B. Ellis

2. Date of Death Month Dey Yaer: May 21, 1997

3. Time of Death: 7:15 PM

4a. Facility Name (If not institution, give street end number): Rockville Nursing Home

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 246-16-3970

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 91 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Yeer): April 29,1906

9. Birthplece (Stete or Foreign Country): North Carolina

Usuel Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 303 Adclare Road

10f. Zip Code: 20850

10g. Citizen of Whet Country?: United States of America

11. Maritel Stetus: 1☐ Never Married 2☐ Merried 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indlen, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed)

Elamentary/Secondary (0-12): 12

Collega (1-4or 5+):

16a. Dacedent's Usuel Occupetion (Giva kind of work done during most of working life. DO NOT usa retired): Homemaker

16b. Kind of Businass/Industry: Own Home

17. Fether's Name (First, Middle, Last): Joseph Wilson Bennett

18. Mother's Name (First, Middle, Maiden Surneme): Regina Lynch

19a. Informent's Name/Reletionship (Type, Print): Saul M. Honigsburg Son-In Law

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 10 Bradley Court Rockville, Maryland 20851

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Nema of cemetery, cremetory or other piece): Sunset Cemetery

Dete: 5-26-97

20c. Location - City or Town, Stete: Shelby, NC

21. Signature of Funeral Service Licensee: Howard Causan #M00690

22. Name end Address of Facility: Harris Funeral Home 28086
108 South Piedmont Avenue, Kings Mountain, NC

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Entar tha diseese, or complicetions thet ceused the death. Do not anter the mode of dying, such es cerdiac or raspiratory errest, shock, or heert failure. List only one ceuse on each lina.

Approximete Intervel Batween Onset end Death

Immediete Ceusa (Finel disease or condition resulting in deeth)

e. Pnaumonia — Dua to (or as e consaquence of):

Sequentielly list conditions, if eny, leading to immediete ceuse. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest

b. — Due to (or es e consequence of):

c. — Due to (or es e consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease
Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an eutopsy performed? 1☐ Yes 2☒ No

24b. Wara eutopsy findings eveileble prior to completion of cause of daeth? 1☐ Yes 2☐ No

25. Was cese refarrad to medicel exeminer? 1☐ Yes 2☒ No

26. Piece of Death (Check only ona) Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residance 6☐ Other (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒ **Certifying Phyeician:** To the best of my knowledge, deeth occurred et the time, date and piece, end due to the ceusa(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of exemination end/or invastigation, in my opinion, daath occurred et the time, data and place, and due to the ceuse(s) and menner steted.

29b. Signeture end title of certifier: Paul T. Noone MD

29c. License number: DO7471

29d. Date signed (Month, Day, Year): 12 May 97

30. Name and eddress of person who completed ceuse of deeth (Item 23a) (Type, Print): Paul T. Noone, M.D. 50 W. Edmonston Drive, #207 Rockville, MD 20852-1290

State Registrar

31. Dete filed (Month, Day, Year): MAY 30 1997

32. Registrer's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17234

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): NORMA ORDITH EDLER

2. Date of Death Month: May Day: 20 Year: 1997

3. Time of Death: 1530

4e. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 217-12-4372

6. Sex: 1☐ M 2☑ F

7. Age (In yrs. last birthday): 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10/25/1920

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: SOMERSET

10c. City, Town or Location: PRINCESS ANNE

10d. Inside City Limits: 1☑ Yes 2☐ No

10e. Street and Number: 11411 OLD PRINCESS ANNE ROAD

10f. Zip Code: 21853

10g. Citizen of What Country: U.S.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☑ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSEWIFE

16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): LLOYD TALMADGE WIDDOWSON

18. Mother's Name (First, Middle, Maiden Surname): CHRISTINA METZ

19e. Informant's Name/Relationship (Type, Print): LOGAN WIDDOWSON/NEPHEW

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 30500 PRINCE WILLIAM ST., PRINCESS ANNE, MD. 21853

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): ST. ANDREWS EPISCOPAL CEM Date: 5/24/97

20c. Location - City or Town, State: PRINCESS ANNE, MD.

21. Signature of Funeral Service Licensee: James P. Hinman MD0295

22. Name and Address of Facility: HINMAN FUNERAL HOME 11673 SOMERSET AVE., PRINCESS ANNE, MD. 21853

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Acute Renal Failure	4wks
Due to (or as a consequence of): b.	Congestive Heart Failure	4wks
Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last. Due to (or as a consequence of): c.	Systemic Lupus Erythematosus	?
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HTN

COPD

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] D.O.

29c. License number: H50397

29d. Date signed (Month, Day, Year): 5/20/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Chris Snyder D.O. 108 Pine Bluff RD Salisbury MD 21801

State Registrar

31. Date filed (Month, Day, Year): MAY 23 1997

32. Registrar's Signature: Julia Brooks-Randall

DHMH 16 Rev 6/95

Norma Elder

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17235

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: David Wilson Eichhorn

2. Dete of Deeth Month: 05 Dey: 09 Yeer: 1997

3. Time of Death: 2:00PM

4e. Feclility Neme *(If not institution, give street end number)*: 1216 N. Main Street

4b. City, Town, or Location of Death: Hampstead

4c. County of Deeth: Carroll

Funeral Director

5. Sociel Security Number: 206-34-6772

6. Sex: 1 M 2 F

7. Age *(In yrs. lest birthday)*: 53 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Yeer)*: 11-03-1943

9. Birthplace *(State or Foreign Country)*: PENNSYLVANIA

Usuel Residence of Decedent

10e. Stete: MARYLAND

10b. County: CARROLL

10c. City, Town or Location: HAMPSTEAD

10d. Inside City Limits: X Yes 2 No

10e. Street end Number: 1216 NORTH MAIN STREET APT 2

10f. Zip Code: 21074

10g. Citizen of What Country?: USA

11. Marital Stetus: 1 Never Married 2 Married 3 Widowed 4 X Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Yes 2 No *Specify:*

14. Reca - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*: Elemantary/Secondary (0-12): 12; Collaga (1-4or 5+):

16e. Dacedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: TRUCK DRIVER

16b. Kind of Business/Industry: TRUCK DRIVING

17. Father's Name *(First, Middle, Last)*: ALFRED WILLIAM EICHHORN

18. Mother's Neme *(First, Middle, Meiden Surname)*: HELEN WILSON

19e. Informent's Name/Reletionship *(Type, Print)*: TRACI SMITH, DAUGHTER

19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, State, Zip Code)*: 860 CENTURY ST, HAMPSTEAD, MD 21074

20a. Method of Disposition: 1 Burial 2 X Cremetion 3 Removel from State 4 Donetion 5 Other *(Specify)*

20b. Pleca of Disposition *(Name of cemetery, cremetory or other piece)*: CARROLL CREMATIONS

Date: 5/11

20c. Location - City or Town, Steta: HAMPSTEAD, MD

21. Signeture of Funerel Service Licensee: Steven W Eline

22. Name and Address of Facility: ELINE FUNERAL HOME 934 SOUTH MAIN ST, HAMPSTEAD, MD 21074

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only one ceusa on aach lina.

Approximeta Intervel Between Onsat end Death

Immediate Ceuse (Finel diseese or condition resulting in death)
e. Arrhythmia — <15min

Due to (or as e consaquanca of):
b. Atrial fibrillation — mo

Saquentially list conditions, if any, leeding to immedeite causa. Entar Underlying Cause (Disease or Injury thet Initieted events resulting in death) Last

Dua to (or as e consequenca of):
c. Coronary Artery Disease — 15 yr

Due to (or as a consequence of):
d. Diabetes — yrs.

Pert II. **Other significant conditione** contributing to death but not rasulting in the underlying cause given in Pert I.

COPD
Sleep apnea
Morbid obesity
Recent necrotizing fasciitis L thigh & long hospitalizatio (ventilator dependency 4/97)

23b. **Did tobacco use contribute to the cause of death?** 1 Yes 2 No 3 Probably 4 X Unknown

24a. Was an eutopsy performed? 1 Yes 2 X No

24b. Were eutopsy findings eveileble prior to completion of cause of daath? 1 Yes 2 No

25. Wes case referred to medicel exeminer? 1 Yes 2 X No

26. Plece of Daath *(Check only one)*: Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA; Other: 4 Nursing Home 5 X Residenca 6 Other *(Specify)*

27. Menner of Deeth: 1 X Naturel 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28e. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 X **Certifying Phyeician**: To tha best of my knowladga, daath occurred at tha tima, data and plece, and dua to tha causa(s) and mannar as stated. 2 **Medical Examiner**: On tha basis of exeminetion end/or investigetion, in my opinion, daeth occurred et tha time, dete end pleca, end due to the causa(s) end menner stated.

29b. Signeture end titla of certifier: Catherine B Heilman MD

29c. License number: D47515 - MD

29d. Date signed *(Month, Dey, Yeer)*: May 10, 1997

30. Neme end eddress of person who completed causa of daath (Item 23a) (Type, Print): Catherine B Heilman MD

State Registrar

31. Dete filed *(Month, Dey, Yaar)*: MAY 16 1997

32. Registrer's Signature: Julia A Barker Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17236

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Glenn G. Edwards, Jr.

2. Date of Death — Month: May; Day: 20; Year: 1997

3. Time of Death: 16:50 pm

4a. Facility Name *(If not institution, give street and number)*: Union Hospital of Cecil County

4b. City, Town, or Location of Death: Elkton

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 705-09-7343

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 79 Yrs.

If Under 1 Year — Months: ; Days:

If Under 24 Hrs. — Hours: ; Min.:

8. Date of Birth *(Month, Day, Year)*: October 16, 1917

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Cecil

10c. City, Town or Location: North East

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 14 Lincoln Avenue

10f. Zip Code: 21901

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No — If Yes, Give Year or Dates: WWII US Army

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Safety Department

16b. Kind of Business/Industry: Railroad

17. Father's Name *(First, Middle, Last)*: Glenn G. Edwards, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Malissa Poe

19a. Informant's Name/Relationship *(Type, Print)*: Nellie Mae Edwards / Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 14 Lincoln Avenue, North East, MD 21901

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Memory Gardens Cemetery

Date: May 26 1997

20c. Location - City or Town, State: Lake Worth, Florida

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: Crouch Funeral Home, 127 South Main Street, North East, MD 21901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Aspiration Pneumonia	6 days
Due to (or as s consequence of): b.	Amyotrophic Lateral Sclerosis	3 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death *(Check only one)*: Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Sachdev S. MD

29c. License number: D23322

29d. Date signed *(Month, Day, Year)*: 5/22/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): S. S. SACHDEV MD, 322E Cecil Ave North East MD 21901

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 22 1997

32. Registrar's Signature: Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17237

Physician /Medical Examiner

1. Decedent's Nema *(First, Middle, Last)*: WILLIAM L. ENGLISH
2. Date of Deeth Month: MAY Day: 20, Yeer: 1997
3. Time of Deeth: 6:35 A.M.
4e. Facility Nema *(If not institution, give streat and number)*: Suburban Hospital
4b. City, Town, or Location of Death: Bethesda
4c. County of Deeth: Montgomery

Funeral Director

5. Social Security Number: 218-34-6271
6. Sex: 1☒M 2☐F
7. Age *(In yrs. last birthdey)*: 60 Yrs. — If Under 1 Yaar: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Day, Year)*: May 15, 1937
9. Birthpleca *(State or Foreign Country)*: Wash., D.C.

Usual Residence of Decedent

10a. Stete: Md.
10b. County: Queen Anne's
10c. City, Town or Location: Grasonville
10d. Inside City Limits: 1☐Yas 2☒No

10e. Street and Number: 625 Chester River Beach Rd.
10f. Zip Code: 21638
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Navar Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armad Forces? 1☐Yes 2☒No If Yas, Give Year or Detas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Maxican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - Amarican Indian, Black, White, etc. *Specify:* White

15. Decedent's Eduction *(Specify only highest greda completed)*: Elementery/Secondary (0-12): 12 — College (1-4or 5+): 4
16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Personnel Admin.
16b. Kind of Business/Industry: E.P.A.

17. Fether's Neme *(First, Middle, Last)*: Stephen English
18. Mother's Name *(First, Middle, Maiden Surneme)*: Anna Hargis

19e. Informent's Name/Relationship *(Type, Print)*: Cecelia G. English (Wife)
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 625 Chester River Beach Rd., Grasonville, Md. 21638

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donetion 5☐Other *(Specify)*
20b. Plece of Disposition *(Neme of cemetery, cremetory or othar place)*: Chesapeake Cremation Center — Date: May 22, 1997
20c. Location - City or Town, Stete: Stevensville, Md.

21. Signature of Funerel Servica Licansae: ▶ Thomas K. Helfenbein
22. Name and Addrass of Facility: Fellows, Helfenbein & Newnam Funeral Home, 106 Shamrock Rd., Chester, Md. 21619

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the daath. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on eech line.

		Approximate Intervel Between Onsat and Deeth
Immediete Cause (Finel diseese or condition resulting in death)	e. MYOCARDIAL INFARCTION	24 HRS.
Due to (or es e consequence of):	b. END STAGE RENAL DISEASE	MONTHS
Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initiated events resulting in deeth) Last — Due to (or es e consequence of):	c. PERITONITIS	DAYS
Due to (or es a consequence of):	d. DIABETES	YEARS

Part II. **Other elgnificant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. **Did tobacco use contribute to tha cauea of death?** 1☐**Yes** 2☐**No** 3☐**Probably** 4☐**Unknown**

24a. Was en eutopsy performad? 1☐Yas 2☐No

24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 1☐Yes 2☐No

25. Wes case referred to medicel examiner? 1☐Yes 2☐No

26. Place of Deeth *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpetient 3☐DOA — Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Menner of Deeth: 1☐Naturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Yeer)*
28b. Time of Injury
28c. Injury et Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☐ **Certifying Phyeician:** To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.
2☐ **Medical Examiner:** On the besis of exemination end/or investigation, in my opinion, death occurred et the time, dete end plece, end due to the ceuse(s) end menner steted.

29b. Signeture and title of certifier: ▶ Mary Ann Lange, M.D.
29c. License number: D37504
29d. Date signed *(Month, Dey, Yeer)*: 5-20-97

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print): MARY ANN LANGE, M.D., 8400 THORNDEN TERRACE, BETHESDA MD 20817

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 22 1997
32. Registrar's Signature: ▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17238

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lois Gertrude Edwards

2. Date of Death (Month, Day, Year): May 19, 1997

3. Time of Death: 2:15 am

4a. Facility Name (If not institution, give street and number): 3619 Gallatin Street

4b. City, Town, or Location of Death: Hyattsville

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 578-46-3422

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 62 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 12, 1935

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD

10b. County: Prince George's

10c. City, Town or Location: Hyattsville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3619 Gallatin Street #913

10f. Zip Code: 20782

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary / Bookkeeper

16b. Kind of Business/Industry: Private Industry

17. Father's Name (First, Middle, Last): Lynwood Livingston

18. Mother's Name (First, Middle, Maidan Surname): Elise Densmore Fields

19a. Informant's Name/Relationship (Type, Print): Georganne Boyer Simmons - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3619 Gallatin Street #913, Hyattsville, MD 20782

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MD Veteran's Cemetery

Date: 05/22/97

20c. Location - City or Town, State: Crownsville, Maryland

21. Signature of Funeral Service Licensee: ▶ Nancy J. Thompson

22. Name and Address of Facility: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE

Due to (or as a consequence of):

b. EMPHYSEMA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CROHNS DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Neil A. Meade M.D.

29c. License number: D19220

29d. Date signed (Month, Day, Year): 5-21-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Neil A. Meade, M.D. 9811 Mallard Drive #205, Laurel, Maryland 20708-3179

State Registrar

31. Date filed (Month, Day, Year): MAY 22 1997

32. Registrar's Signature: John Anderson Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17239

Physician /Medical Examiner

1. Decedant's Neme (First, Middle, Last): OLIVIA EASON

2. Dete of Deeth — Month: MAY; Dey: 17; Yeer: 97

3. Time of Deeth: 2:10 PM

4e. Facility Neme (If not institution, giva street and number): PRINCE GEORGES HOSPITAL

4b. City, Town, or Location of Deeth: CHEVERLY

4c. County of Deeth: PRINCE GEORGES

Funeral Director

5. Social Security Number: 238-64-8785

6. Sax: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 56 Yrs.

If Under 1 Yaar — Months: ; Days:

If Under 24 Hrs. — Hours: ; Min.:

8. Date of Birth (Month, Day, Yaar): JUN 19 40

9. Birthplace (State or Foraign Country): NORTH CAROLINA

Usual Residenca of Decadent

10a. Stete: MD

10b. County: PRINCE GEORGES

10c. City, Town or Location: LARGO

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 10137 PRINCE PLACE #103

10f. Zip Code: 20772

10g. Citizan of Whet Country?: U.S.A.

11. Marital Status: 1☒ Never Merried 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decadent Ever in U,S. Armed Forcas? 1☐ Yes 2☒ No — If Yes, Give Yaer or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuben, Maxican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elamantary/Secondery (0-12): 12TH

Collaga (1-4or 5+):

16e. Dacedant's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): UNEMPLOYED

16b. Kind of Business/Industry: NONE

17. Fether's Nema (First, Middla, Last): JOHN L. EASON

18. Mother's Name (First, Middle, Maiden Surname): DORA LASSISTER

19a. Informent's Name/Reletionship (Type, Print): BRENDA BLACK-DAUGHTER

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code): 4465 23RD PARKWAY #202 TEMPLE HILLS,MD 20748

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Othar (Specify)

20b. Placa of Disposition (Name of cemetery, crematory or othar placa): MARYLAND NATIONAL CEM.

Dete: MAY 24 97

20c. Location - City or Town, State: LAUREL,MD

21. Signeture of Funeral Service Licensee: W. H. Bacon 276

22. Name and Address of Facility: W.H. BACON FUNERAL HOME INC. 3447 14TH STREET,N.W. WASH, D.C. 20010

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications thet caused tha deeth. Do not antar the moda of dying, such as cardiac or raspiratory errest, shock, or heart feilure. List only ona cause on eech iine.

Approximata Intarval Between Onset end Deeth

Immediete Ceusa (Final disease or condition resulting in daath)

e. Carcinoma of lung — Due to (or as a consequance of):

9 mo

Sequantially iist conditions, if eny, leeding to immedieta cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest

b. — Due to (or es e consequanca of):

c. — Due to (or es e consequenca of):

d.

Part II. **Other signficant conditions** contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to ths cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of causa of death? 1☐ Yes 2☐ No

25. Was casa referred to medical exeminar? 1☐ Yes 2☒ No

26. Place of Deeth (Check only ona)

Hospitel: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residenca 6☐ Othar (Specify)

27. Menner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending Investigation 6☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Placa of injury - At home, ferm, street, fectory, offica buiiding, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physicien:** To the best of my knowledge, daath occurred et the time, dete end place, and due to the ceuse(s) end mannar as stated. 2☐ **Medical Examiner:** On the basis of exemination end/or Investigation, in my opinion, deeth occurred at tha tima, date end pieca, end dua to tha causa(s) end menner steted.

29b. Signature and title of certifier: H Thomas Foley MD.

29c. Licanse number: D05898

29d. Date signed (Month, Day, Yaar): 5-19-97

30. Nama and eddress of person who completed cause of death (item 23e) (Type, Print): H. Thomas Foley, M.D., Prince George's Hosp. Cen., Cheverly, MD 20785

State Registrar

31. Dete filed (Month, Day, Yaar): MAY 22 1997

32. Registrer's Signeture: Julia Madison-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

3

WRC
97-2790-003
CASSEY
EDWARDS

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17240

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Cassey Lynn Edwards
2. Date of Death (Month, Day, Year): MAY 19, 1997
3. Time of Death: 8:57 AM
4a. Facility Name (If not institution, give street and number): NORTH ARUNDEL HOSPITAL
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 217-33-0643
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 5 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): September 5,1991
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: St. Mary's
10c. City, Town or Location: Mechanicsville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 27288 Queen Tree Road
10f. Zip Code: 20659
10g. Citizen of What Country?: USA

11. Meritel Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): K; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Student
16b. Kind of Business/Industry:

17. Father's Name (First, Middle, Last): William Wesley Edwards
18. Mother's Name (First, Middle, Maiden Surname): Carolyn Valerie Morgan

19a. Informant's Name/Relationship (Type, Print): Carolyn V. Edwards Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 27288 Queen Tree Road, Mechanicsville, MD 20659

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Charles Memorial Gardens
Date: 5/21/97
20c. Location - City or Town, State: Leonardtown, MD

21. Signature of Funeral Service Licensee: Michael K Gardiner
22. Name and Address of Facility: Mattingley-Gardiner Funeral Home, P.A. 41590 Fenwick St. P.O. Box 270, Leonardtown, MD 20650

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): e. Sepsis
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Congenital Intestinal Denervation
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: J. Luther Cooke MD
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): MAY 20, 1997
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): J. Luther Cooke, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): MAY 21 1997
32. Registrar's Signature: Julie Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17241

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Amy Victoria Etzler

2. Date of Death Month: May Day: 21 Year: 1997

3. Time of Death: 2:45 PM

4e. Facility Name *(If not institution, give street and number)*: Northampton Manor Nursing Home

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 217-36-2970 B

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 94 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Feb. 4, 1903

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 216 East Street

10f. Zip Code: 21701

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elamantary/Secondary (0-12): 7th | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT usa ratired)*: Farmers Wife

16b. Kind of Business/Industry: N/A

17. Father's Name *(First, Middle, Last)*: David W. Martin

18. Mother's Name *(First, Middle, Maiden Surname)*: Rachel Ruth Nusbaum

19a. Informant's Name/Ralationship *(Type, Print)*: Wilma Hood (Daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Coda)*: 5405 Buffalo Rd. Mount Airy, MD 21771

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stete 4☐ Donation 5☐ Other *(Specify)*

20b. Piece of Disposition *(Name of cemetery, crematory or other place)*: Locust Grove Cemtery | Date: May 24, 1997 | 20c. Location - City or Town, State: Mount Airy, MD

21. Signature of Funeral Service Licensee: Bob A. Keller

22. Name and Address of Facility: Burrier-Queen Funeral Home 1212 W. Old Liberty Rd. Winfield, MD 21784

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or resptratory arrast, shock, or heart failure. List only one ceuse on each line. | Approximate tntarval Between Onset and Death

Immediate Cause (Finat disease or condition rasulting in death): a. Sepsis

Dua to (or as a consequence of): b. Bowel obstruction

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Diseese or injury that initiated events resulting in death) Lest

Due to (or as e consequence of): c. CA of Bowel.

Due to (or as e consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause givan in Part I.: alzheimers dementia

23b. **Did tobacco use contributa to the cause of death?** 1☐ **Yes** 2☒ **No** 3☐ **Probably** 4☐ **Unknown**

24a. Wes an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to completion of cause of daath? 1☐ Yas 2☐ No

25. Was case rafarrad to medical examiner? 1☐ Yes 2☒ No

28. Placa of Daath *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)* | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Dascribe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. *(Specify)* | 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledge, daath occurred at tima, data and place, and due to the causa(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D26499

29d. Date signed *(Month, Day, Year)*: 5/22/97

30. Nama and address of person who complatad cause of daath (Item 23e) (Type, Print): Dr. Ronald Miller, P.O. Box 210, Mt. Airy, MD 21771

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours eftar death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 22 1997

32. Registrar's Signature: Julia Thurlow Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17242

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: PAUL ALLEN EYLER

2. Date of Death Month / Day / Year: MAY 18, 1997

3. Time of Death: 1 40 PM

4a. Facility Name *(If not institution, give street and number)*: 29 W. MAIN ST.

4b. City, Town, or Location of Death: EMMITSBURG

4c. County of Death: FREDERICK

Funeral Director

5. Social Security Number: 217-28-1046

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 65 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: OCT. 4, 1931

9. Birthplace *(State or Foreign Country)*: THURMONT, MD.

Usual Residence of Decedent

10a. State: MD

10b. County: FREDERICK

10c. City, Town or Location: EMMITSBURG

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 29 W. MAIN ST.

10f. Zip Code: 21727

10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: LABORER

16b. Kind of Business/Industry: GROUNDS CREW

17. Father's Name *(First, Middle, Last)*: ROSCOE OLEN EYLER

18. Mother's Name *(First, Middle, Maiden Surname)*: HELEN MARIE WETZEL

19a. Informent's Name/Relationship *(Type, Print)*: LEDLIE EYLER

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 15925 ST. ANTHONY'S RD., THURMONT, MD. 21788

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: ST. ANTHONY'S SHRINE Date: 5/22/97

20c. Location - City or Town, State: EMMITSBURG, MD.

21. Signature of Funeral Service Licensee: John M. Skiles

22. Name and Address of Facility: SKILES FUNERAL HOME 210 W. MAIN ST., EMMITSBURG, MD. 21727

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)
e. Cardiac Arrest — <10sec

Due to (or as a consequence of):
b. Coronary Artery Disease — 10yrs

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last
Due to (or as a consequence of):
c. with Cardiac Arrhythmia — 2 yrs

Due to (or as e consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other *(Specify)*

27. Menner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Sulcide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete end plece, end due to the ceuse(s) end menner es steted. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: Alan Carroll MD

29c. License number: D 18705

29d. Date signed *(Month, Day, Year)*: 19 MAY 1997

30. Name end address of person who completed cause of death (Item 23e) (Type, Print): ALAN CARROLL, M.D., 310 S. SETON AVE., EMMITSBURG, MD. 21727

State Registrar

31. Dete filed *(Month, Day, Year)*: MAY 20 1997

32. Registrar's Signature: Lisa Sheridan-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17243

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edward Vincent ECHLE

2. Date of Death Month May Day 16, Year 1997

3. Time of Death: 7:00 pm

4a. Facility Name (If not institution, give street and number): Saint Catherine's Nursing Center

4b. City, Town, or Location of Death: Emmitsburg

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 216-16-2729

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 78 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): Dec 28, 1918

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedant

10a. Stata: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1☒ Yas 2☐ No

10e. Street and Number: 115 East Second Street

10f. Zip Coda: 21701

10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1☒ Nevar Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedant Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:

14. Race - American Indian, Black, White, atc. Specify: White

15. Decedent's Education (Specify only highest grada completed): Elamantary/Secondary (0-12): Collega (1-4or 5+): 5+

16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired): Priest/Monsignor

16b. Kind of Businass/Industry: Religion/Catholic

17. Fathar's Nama (First, Middla, Last): Harry A ECHLE Sr

18. Mothar's Nama (First, Middle, Maiden Surname): Frances M RILEY

19a. Informant's Name/Ralationship (Type, Print): Father Wayne G. Funk/Associate

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code): 116 East Second Street, Frederick, Maryland 21701

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): New Cathedral Cemetery

Data: May 21, 1997

20c. Location - City or Town, Stata: Baltimore, MD

21. Signature of Funeral Service Licensee: Kathryn R Berson

22. Nama and Address of Facility: Keeney & Basford P.A. Funeral Home 106 E Church Street, Frederick, Maryland 21701

Physician /Medical Examiner

23a. Part I. Entar the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only one cause on each line.

Approximata Intarval Batwaen Onsat and Death

Immediata Causa (Final disaasa or condition rasulting in death)

a. Alzheimer's dz

Due to (or as a consequence of):

b. and Multiple Myeloma — several YRS

Sequantially list conditions, if any, laading to immadiata cause. Enter Undarlying Causa (Disaasa or injury that initiatad avants rasulting in daath) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

atrial fibrillation

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Ware autopsy findings available prior to completion of cause of daath? 1☐ Yas 2☒ No

25. Was casa rafarrad to medical examinar? 1☐ Yas 2☒ No

28. Placa of Death (Check only ona)

Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA

Othar: 4☐ Nursing Homa 5☐ Rasidance 8☐ Othar (Specify)

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarmined

28a. Data of Injury (Month, Day Yaar)

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Placa of Injury - At homa, farm, streat, factory, offica building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledga, daath occurrad at tha tima, date and placa, and due to the cause(s) and mannar as stated. 2☐ Medical Examiner: On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar stated.

29b. Signatura and titla of certifier: C Curley MD

29c. Licansa number: D39937

29d. Data signad (Month, Day, Year): 5/19/97

30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print): Christine A. Curley, M.D., 302 West Main Street, Emmitsburg, Maryland 21727

State Registrar

31. Data filed (Month, Day, Year): MAY 20 1997

32. Registrar's Signature: Sheridan Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17244

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LEROY FARINGER

2. Date of Death: Month MAY Day 17 Year 1997

3. Time of Death: 5:51 PM

4a. Facility Name (If not institution, give street and number): Holy Cross Hospital

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 431-07-8425

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept 11, 1917

9. Birthplace (State or Foreign Country): Arkansas

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 12813 Stonecrest Dr

10f. Zip Code: 20904

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Lieutenant Colonel

16b. Kind of Business/Industry: US Air Force

17. Father's Name (First, Middle, Last): Leroy Faringer

18. Mother's Name (First, Middle, Maiden Surname): Florence Myane

19a. Informant's Name/Relationship (Type, Print): Fahy E. Faringer

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12813 Stonecrest Dr, Silver Spring, MD 20904

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Arlington National

Date: May 27

20c. Location - City or Town, State: Arlington, VA

21. Signature of Funeral Service Licensee: Alan J. Donnell

22. Name and Address of Facility: Hines-Rinaldi Funeral Home 11800 New Hampshire Ave, Silver Spring, MD 20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Septicemia — hours

Due to (or as a consequence of): Myelo proliferative Disorder — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury: M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D08546

29d. Date signed (Month, Day, Year): May 18 97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John Faulkner 8218 Wisconsin Ave Bethesda

State Registrar

31. Date filed (Month, Day, Year): MAY 20 1997

32. Registrar's Signature: Jane Dickson Randall

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17245

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Clara E. Ferris

2. Dete of Deeth — Month: May — Dey: 14, — Year: 1997

3. Time of Deeth: 7:30 P.M.

4e. Feciility Neme *(If not institution, give street end number)*: Collingswood Nursing Center

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Sociel Security Number: 308-26-1170

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthdey)*: 80 Yrs.

If Under 1 Yeer: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Yeer)*: Dec. 29, 1916

9. Birthplece *(Stete or Foreign Country)*: Pennsylvania

Usuel Residence of Decedent

10a. Stete: Maryland

10b. County: Montgomery

10c. City, Town or Locetion: Bethesda

10d. Inside Clty Limits: 1☐ Yes 2☒ No

10e. Street and Number: 9904 Derbyshire Lane

10f. Zip Code: 20817

10g. Citizen of What Country?: United States

11. Merital Stetus: 1☐ Never Merried 2☐ Merried 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1☐ Yes 2☒ No *Specify:*

14. Rece - Americen Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Fether's Neme *(First, Middle, Last)*: Henry Morris Davies

18. Mother's Neme *(First, Middle, Maiden Surneme)*: Lizzie Rebecca Kocher

19e. Informent's Neme/Relationship *(Type, Print)*: Anita F. Allison / daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 174 Gold Kettle Drive, Gaithersburg, Maryland 20878-2705

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Montgomery Crematorium, Inc. — Date: May 17, 1997

20c. Locetion - City or Town, Stete: Bethesda, Maryland

21. Signeture of Funeral Service Licensee: Barbara J. McMillen Lawrence M00831

22. Neme end Address of Feciility: Robert A. Pumphrey Funeral Home / Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Pert I. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one cause on eech line.

Approximete Interval Between Onset end Deeth

Immediete Cause (Finel diseese or condition resulting in deeth)

a. Carcinomatosis — 2 years

Due to (or es a consequence of):

Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in deeth) Lest

b. Carcinoma of Lung

Due to (or es e consequence of):

c.

Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Cerebral Metastases, Anemia, Hypertensive Arteriosclerotic Cardiovascular Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings aveilebie prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Plece of Deeth *(Check only one)*: Hospital: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28e. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Locetion *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physicien**: To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) end menner es stated. 2☐ **Medical Examiner**: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete and piece, and due to the ceuse(s) end menner stated.

29b. Signeture end title of certifier: H. Robert Birschbach, M.D.

29c. License number: D04115

29d. Dete signed *(Month, Day, Year)*: May 15, 1997

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print): H. Robert Birschbach, M.D., 6320 Democracy Blvd., Bethesda, MD 20817

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: MAY 19 1997

32. Registrer's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17246

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Helen A. Fishman

2. Date of Death: Month May Day 20 Year 1997

3. Time of Death: 2:10A.M.

4a. Facility Name (If not institution, give street and number): Sharon House Nursing Home

4b. City, Town, or Location of Death: Olney

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-07-3939

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 86 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 24, 1910

9. Birthplace (State or Foreign Country): Balt.MD.

Usual Residence of Decedent

10a. State: Md.

10b. County: Montgomery

10c. City, Town or Location: Olney

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 18201 Slade School Rd.

10f. Zip Code: 20860

10g. Citizen of What Country? US

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Dental Assistant

16b. Kind of Business/Industry: Dentistry

17. Father's Name (First, Middle, Last): William Abrams

18. Mother's Name (First, Middle, Maiden Surname): Jenny Greenfeld

19a. Informant's Name/Relationship (Type, Print): Lynda Epstein/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1716 Shilling Lane Silver Spring, Md. 20906

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Judean Memorial Gardens

Date: 5/22

20c. Location - City or Town, State: Olney, Md.

21. Signature of Funeral Service Licensee: Edward Sagel

22. Name and Address of Facility: Edward Sagel Funeral Direction 1091 Rockville Pike Rockville, Md. 20852

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE — 48 HOURS

Due to (or as a consequence of):

b. MYOCARDIAL INFARCTION — 48 HOURS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ALHEIMER'S DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ted Howe.

29c. License number: D33700

29d. Date signed (Month, Day, Year): MAY 20, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ted E. Howe M.D. 7542 Overlook Dr. Boonsboro, MD 21713

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12

State Registrar

31. Date filed (Month, Day, Year): MAY 23 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17247

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Maitland Kirk Flood
2. Date of Death Month: May Day: 17 Year: 1997
3. Time of Death: 1005AM
4a. Facility Name *(If not institution, give street and number)*: SHADY GROVE ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 578-40-5034
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 63 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: AUG. 14, 1933
9. Birthplace *(State or Foreign Country)*: WASH. D.C.

Usual Residence of Decedent

10a. State: MD.
10b. County: MONTGOMERY
10c. City, Town or Location: GERMANTOWN
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 11425 NEELSVILLE CHURCH RD.
10f. Zip Code: 20876
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): / College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: COMPUTER ENGINEER
16b. Kind of Business/Industry: COMPUTERS

17. Father's Name *(First, Middle, Last)*: FRANCIS FLOOD
18. Mother's Name *(First, Middle, Maiden Surname)*: JANET MAITLAND

19a. Informant's Name/Relationship *(Type, Print)*: MYRA J. FLOOD/WIFE
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: SAME AS ITEM #10

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: CHAMBERS CREMATORY
Date: 5/20
20c. Location - City or Town, State: RIVERDALE, MD.

21. Signature of Funeral Service Licensee: W. W. Chambers MO0091
22. Name and Address of Facility: CHAMBERS FUNERAL HOMES, P.A., SILVER SPRING, MD. 20910

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. MYOCARDIAL INFARCTION — 30 MINUTES

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. CORONARY ARTERY disease — years

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other *(Specify)*
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and Title of Certifier: M.D.
29c. License number: D37024
29d. Date signed *(Month, Day, Year)*: MAY 17, 1997
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID SROUR 9901 Medical Center Drive Rockville Md. 20850

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 20 1997
32. Registrar's Signature: Gina Davidson-Randall

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17248

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Evelyn Banker Flynn

2. Date of Death Month / Day / Year: May 16 1997

3. Time of Death: 6:55 AM

4a. Facility Name *(If not institution, give street and number)*: Mariner Health Care - Circle Manor

4b. City, Town, or Location of Death: Kensington

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 086-18-7618

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 92 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 24,1905

9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 118 Monroe Street Apt.903

10f. Zip Code: 20850

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Sales

16b. Kind of Business/Industry: Interior Designs

17. Father's Name *(First, Middle, Last)*: William Banker

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Dugan

19a. Informant's Name/Relationship *(Type, Print)*: Marie Gwendolyn Gracia

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 118 Monroe Street #903, Rockville,Maryland 20850

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cemetery

Date: 5/21/97

20c. Location - City or Town, State: Silver Spring,Maryland

21. Signature of Funeral Service Licensee: Steven D Stine

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd.,W.,Sil.Spr.,Maryland 20901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia — 3 Days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jeanne P Asher MD

29c. License number: D 34032

29d. Date signed *(Month, Day, Year)*: May 16, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jeanne P. Asher, M.D. 3720 Farragut Avenue Kensington,Maryland 20895

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 19 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17249

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Margaret Ripka Foremon
2. Date of Death — Month: May; Day: 19; Year: 1997
3. Time of Death: 5:15 PM
4a. Facility Name *(If not institution, give street and number)*: Wilson Health Care Center
4b. City, Town, or Location of Death: Gaithersburg
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 166-16-1086
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 85 Yrs.
If Under 1 Year — Months: ; Days:
If Under 24 Hrs. — Hours: ; Min.:
8. Date of Birth *(Month, Day, Year)*: March 22, 1912
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Germantown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 14315 Long Channel Drive
10f. Zip Code: 20874
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Home

17. Father's Name *(First, Middle, Last)*: William MacIntyre
18. Mother's Name *(First, Middle, Maiden Surname)*: Elizabeth Prout

19a. Informant's Name/Relationship *(Type, Print)*: Valerie Jardine/Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 14315 Long Channel Drive, Germantown, MD. 20874

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Arlington National Cem.
Date: 5/29/97
20c. Location - City or Town, State: Arlington, Virginia

21. Signature of Funeral Service Licensee: Michael D. Gilbert
22. Name and Address of Facility: DeVol Funeral Home, 10 E. Deer Park Dr., Gaithersburg, MD. 20877

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Pyelonephritis — Approximate Interval: 5 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: 07231
29d. Date signed *(Month, Day, Year)*: May 19, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James R. Moore, 207 Brookes Ave Gaithersburg MD 20877

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 21 1997
32. Registrar's Signature: Linda Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17250

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Derrick Guy Fitzhugh

2. Date of Death Month / Day / Year: May 22 1997

3. Time of Death: 10:55AM

4e. Facility Name *(If not institution, give street and number)*: 12090 South College Place

4b. City, Town, or Location of Death: Princess Anne

4c. County of Death: Somerset

Funeral Director

5. Social Security Number: 218-70-4734

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 38 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Aug.6 1958

9. Birthplace *(State or Foreign Country)*: Salisbury

Usual Residence of Decedent

10e. State: Maryland

10b. County: Somerset

10c. City, Town or Location: Princess Anne

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 12090 College Place

10f. Zip Code: 21853

10g. Citizen of What Country?: U.S.A

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12 / College (1-4or 5+):

16e. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Laborer

16b. Kind of Business/Industry: None

17. Father's Name *(First, Middle, Last)*: Henry Fitzhugh

18. Mother's Name *(First, Middle, Maiden Surname)*: Elva Messick

19e. Informant's Name/Relationship *(Type, Print)*: Elva Burns

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 12090 College Place Princess Anne,Md 21853

20e. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Springhill Mem.Garden

Date: 5/27

20c. Location - City or Town, State: Hebron,Md.

21. Signature of Funeral Service Licensee: Gladys B. Stewart

22. Name and Address of Facility: Stewart Funeral Home 821 West Rd.Salisbury,Md.21801

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Chronic Myelogenous Leukemia — 3yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D26278

29d. Date signed *(Month, Day, Year)*: 5-23-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): David Rosenthal, MD 145 E. Camden St. Salisbury, MD 21801

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 23 1997

32. Registrar's Signature: John Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17251

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROBERT W. FORD
2. Date of Death Month: MAY Day: 24 Year: 97
3. Time of Death: 0430
4a. Facility Name (If not institution, give street and number): Atlantic General Hospital
4b. City, Town, or Location of Death: Berlin
4c. County of Death: Worcester

Funeral Director

5. Social Security Number: 206-12-0819
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JULY 12, 1923
9. Birthplace (State or Foreign Country): PENNSYLVANIA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: WORCESTER
10c. City, Town or Location: OCEAN CITY
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 14309 JARVIS AVE.
10f. Zip Code: 21842
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SHIFT SUPERVISOR
16b. Kind of Business/Industry: ELECTRIC UTILITY CO.

17. Father's Name (First, Middle, Last): WALTER FORD
18. Mother's Name (First, Middle, Maiden Surname): PEARL ROBINSON

19a. Informant's Name/Relationship (Type, Print): HILDA FORD
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14309 JARVIS AVE., OCEAN CITY, MD 21842

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): SALISBURY CREMATORY
Date: 5/24/97
20c. Location - City or Town, State: SALISBURY, MD

21. Signature of Funeral Service Licensee: Charles W Hastings
22. Name and Address of Facility: HASTINGS FUNERAL HOME, SELBYVILLE, DE

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death):
a. Coronary artery disease.
Due to (or as a consequence of):
b. End Stage Renal Disease
Due to (or as a consequence of):
c. generalized atherosclerosis
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J Christie MD
29c. License number: D50605
29d. Date signed (Month, Day, Year): May 24 97.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr John Christie 9733 Healthway Dr Berlin Md 21811

State Registrar

31. Date filed (Month, Day, Year): MAY 27 1997
32. Registrar's Signature: Julia Thurlow-Pardell

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17252

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Cynthia Fallon

2. Date of Death: Month: May Day: 24 Year: 1997

3. Time of Death: 08:30

4a. Facility Name (If not institution, give street and number): Anne Arundel Medical Center

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 218-36-4848

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 58 Yrs.

If Under 1 Year: Months / Days

If under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 4 1938

9. Birthplace (State or Foreign Country): Michigan

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: 1☐ Yes 2☐ No XX

10e. Street and Number: 239 Providence Road

10f. Zip Code: 21401

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Legal Assistant

16b. Kind of Business/Industry: Law Office

17. Father's Name (First, Middle, Last): Frederick H. Bradshaw

18. Mother's Name (First, Middle, Maiden Surname): Helen Scnlacnter

19a. Informant's Name/Relationship (Type, Print): William Edwin Fallon

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 6524 Annapolis, Maryland 21401

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Ft. Lincoln Crematory

Date: May 27, 1997

20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Metastatic Carcinoma — 4 mos.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Deep Venous Thrombophlebitis — 1 mos.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Associate Linda D. Burnichandt, MD Pathologist

29c. License number: D45862

29d. Date signed (Month, Day, Year): May 26, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): UNION MEMORIAL HOSPITAL BALTIMORE, MD

State Registrar

31. Date filed (Month, Day, Year): MAY 28 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17253

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Evelyn V. Farlow

2. Data of Daath — Month: 5 Day: 20 Year: 1997

3. Tima of Death: 0730

4a. Facility Name *(If not institution, give street and number)*: 404 Maple Street

4b. City, Town, or Location of Deeth: Pocomoke

4c. County of Death: Worcester

Funeral Director

5. Social Security Number: 219-05-9336

6. Sax: 1☐ M 2☑ F

7. Age *(In yrs. last birthday)*: 86 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: 1-14-1911

9. Birthplaca *(State or Foraign Country)*: Virginia

Usual Residence of Decedant

10a. Stata: Maryland

10b. County: Worcester

10c. City, Town or Location: Pocomoke

10d. Insida City Limits: 1☑ Yas 2☐ No

10e. Street and Number: 404 Maple Street

10f. Zip Code: 21851

10g. Citizen of Whet Country?: USA

11. Maritel Status: 1☐ Never Marriad 2☐ Married 3☑ Widowed 4☐ Divorced

12. Was Dacedent Ever in U.S. Armed Forcas? 1☐ Yes 2☑ No If Yas, Giva Yaar or Detas:

13. Was Dacedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puerto Rican, etc.): 1☐ Yes 2☑ No *Specify:*

14. Race - Amarican Indian, Black, White, etc. *Specify:* white

15. Decedant's Education *(Specify only highest grade completed)*: Elamantary/Secondary (0-12): 7 / Collega (1-4or 5+):

16a. Decedant's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratired)*: Seamstress

16b. Kind of Business/Industry:

17. Fathar's Nama *(First, Middla, Last)*: James C. Maddox

18. Mothar's Nama *(First, Middla, Maidan Surnama)*: Lyda Watson

19a. Informant's Name/Relationship *(Type, Print)*: William F. Farlow/son

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 400 Fifth Street, Pocomoke, Md. 21851

20a. Mathod of Disposition: 1☑ Buriel 2☐ Cramation 3☐ Ramoval from Steta 4☐ Donation 5☐ Other *(Specify)*

20b. Piece of Disposition *(Nama of cematary, crematory or othar place)*: First Baptist Cemetery — Data: 5-23-97

20c. Location - City or Town, Stata: Pocomoke, Md.

21. Signature of Funaral Sarvice Licansaa: Scott S Milsen

22. Nama and Address of Facility: Melson Funeral Home P.O. Box 64, Pocomoke, Md. 21851

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or respiretory errest, shock, or haart failura. List only ona causa on aach line.

Approximate Interval Between Onset and Deeth

Immediata Ceusa (Final disaasa or condition resulting in daath)

a. Myocardial Intarction

Due to (or as a consaquance of):

Sequentially list conditions, if any, leading to immadiata cause. Entar Undarlying Cause (Diseese or Injury that initiated evants resulting in daath) Last

b.

Due to (or as a consequance of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying cause givan in Part I.

Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings availeble prior to completion of cause of death? 1☐ Yas 2☑ No

25. Wes casa rafarred to medical examinar? 1☐ Yas 2☑ No

28. Place of Deeth *(Check only ona)*: Hospitel: 1☐ Inpatiant 2☐ ER/Outpetient 3☐ DOA — Othar: 4☐ Nursing Home 5☒ Residanca 8☐ Othar *(Specify)*

27. Mennar of Death: 1☐ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending invastigation 8☐ Could not be datarmined

28a. Data of Injury *(Month, Day Yaar)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28e. Piece of Injury - At homa, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Steta)*

29e. Certifiar *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledga, daath occurred at tha time, dete end place, and dua to tha causa(s) and manner as stated. 2☐ **Medical Examiner**: On tha basis of axamination and/or invastigetion, in my opinion, daath occurred at tha tima, dete and place, and dua to tha causa(s) and manner stetad.

29b. Signature and tita of certifier: Paul R Fleury

29c. Licansa number: D24872

29d. Date signed *(Month, Day, Yaar)*: 5/28/97

30. Name and addrass of person who compiated causa of death (Item 23a) (Type, Print): PAUL FLEURY 540 Riverside Dr SALISBURY Md

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

8

State Registrar

31. Data filed *(Month, Day, Yaar)*: MAY 27 1997

32. Registrar's Signatura: Julia Proctor Randall

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17254

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Eileen Paula Fuller

2. Dete of Death: Month: May; Dey: 21; Yeer: 1997

3. Time of Death: 5:05 AM

4e. Fecility Neme *(If not institution, give street end number)*: Harford Memorial Hospital

4b. City, Town, or Location of Deeth: Havre de Grace

4c. County of Deeth: Harford

Funeral Director

5. Sociel Security Number: 213-46-0389

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. lest birthday)*: 52 Yrs.

If Under 1 Year: Months; Deys

If Under 24 Hrs.: Hours; Min.

8. Date of Birth *(Month, Day, Year)*: 02-09-1945

9. Birthplece *(Stete or Foreign Country)*: MD

Usuel Residence of Decedent

10a. State: MD

10b. County: Harford

10c. City, Town or Location: Havre de Grace

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 850 Otsego Street

10f. Zip Code: 21078

10g. Citizen of Whet Country?: USA

11. Maritel Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Rece - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Educetion *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12; College (1-4or 5+):

16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Telecommunications Corordinator

16b. Kind of Business/Industry: Telecommunications

17. Fether's Neme *(First, Middle, Last)*: John J. McMahon

18. Mother's Name *(First, Middle, Meiden Surname)*: Kathleen Moran

19e. Informent's Name/Reletionship *(Type, Print)*: Husband Mr. Harry E. Fuller, Sr.

19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 850 Otsego Street, Havre de Grace, MD 21078

20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Harford Memorial Gdns

Dete: 5/24/97

20c. Locetion - City or Town, Stete: Aberdeen, MD

21. Signeture of Funerel Servica Licensee: Eileen L Smith

22. Neme end Address of Feciliry: Mitchell-Smith Funeral Home, P.A. Havre de Grace, MD 21078-3197

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart feilure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Death

Immediete Ceuse (Finel diseese or condition resulting in deeth)

e. CARDIAC ARRYTHMIA — SUDDEN

Due to (or es e consequenca of):

Sequentially list conditions, if any, leeding to immediete ceuse. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest

b. ARTERIOSCLEROTIC CARDIOVASCULAR — YEARS

Due to (or es e consequenca of): DISEASE

c.

Due to (or es e consequenca of):

d.

Pert ii. **Other significant conditfone** contributing to deeth but not resulting in the underlying cause given in Pert f.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes an eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings evelleble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Deeth *(Check only one)*: Hospitel: 1☐ inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of injury - At home, ferm, street, fectory, offica building, etc. *(Specify)*

28f. Locetion *(Street and Number or Rurel Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

29a. Certifier *(Check only one)*: 1☐ Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) end menner es steted. 2☒ Medical Examiner: On the basis of exemination end/or investigetion, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) end menner steted.

29b. Signature and title of certifier: John E. Smialek

29c. License number: OCME

29d. Date signed *(Month, Dey, Yeer)*: 5/21/97

30. Neme end address of person who completed ceuse of deeth (Item 23e) (Type, Print): John E. Smialek, M.D., 111 Penn Street, Baltimore, MD 21201

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: MAY 22 1997

32. Registrar's Signature:

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760,

Fuller, Eileen Paula May 21, 1997 0505

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Amended Items 1 & 2, per F.D. 5/16/97, Carroll County, wjl

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17255

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ~~JANET, Mildred KOCK~~ Janet Mildred Fyock

2. Date of Death: Month ~~5~~ May, Day ~~13~~ 13, Year ~~1997~~ 1997

3. Time of Death: 12:05 pm

4a. Facility Name (If not institution, give street and number): University of Maryland Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 217-32-5668

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 63 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 2, 1933

9. Birthplace (State or Foreign Country): Frederick Co. MD

Usual Residence of Decedent

10a. State: MD

10b. County: Frederick

10c. City, Town or Location: Woodsboro

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 10102 C. Woodsboro Rd.

10f. Zip Code: 21798

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own home

17. Father's Name (First, Middle, Last): Bennie Earl Duncan, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Goldie Young

19a. Informant's Name/Relationship (Type, Print): Micky Fyock/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10102 C. Woodsboro Rd., Woodsboro, MD 21798

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Hope Cemetery

Date: 5/15

20c. Location - City or Town, State: Woodsboro, MD

21. Signature of Funeral Service Licensee: Catharine O. Hartzler

22. Name and Address of Facility: Hartzler Funeral Home, Woodsboro, MD

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. STAPH AUREUS ENDOCARDITIS

Due to (or as a consequence of):

b. SEPSIS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

END STAGE RENAL DISEASE.

DIABETES, HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 8☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Mark Kim, MD

29c. License number: 08733

29d. Date signed (Month, Day, Year): 5/13/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARK KIM, MD 22 S. Greene St. BALTIMORE MD 21201

State Registrar

31. Date filed (Month, Day, Year): MAY 16 1997

32. Registrar's Signature: Julia Davidson Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17256

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: SISTER MARGARET MARY FITZGERALD SND.
2. Data of Death Month Day Yaar: MAY 13, 1997
3. Tima of Death: 3:00 A.M.
4a. Facility Nama *(If not institution, giva straat and numbar)*: ST. CATHERINE'S NURSING CENTER
4b. City, Town, or Location of Daath: EMMITSBURG
4c. County of Daath: FREDERICK

Funeral Director

5. Social Sacurity Numbar: 579-70-5890
6. Sax: 1☐ M 2☒ F
7. Aga *(In yrs. last birthday)*: 94 Yrs.
If Undar 1 Yaar: Months / Days
If Undar 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Yaar)*: SEPT. 10, 1902
9. Birthplaca *(Stata or Foraign Country)*: WASHINGTON, DC

Usual Rasidance of Dacadant

10a. State: MD
10b. County: FREDERICK
10c. City, Town or Location: EMMITSBURG
10d. Insida City Limits: 1☒ Yas 2☐ No
10e. Straat and Numbar: 331 S. SETON AVE.
10f. Zip Coda: 21727
10g. Citizan of What Country?: U. S. A.

11. Marital Status: 1☒ Navar Marriad 2☐ Marriad 3☐ Widowad 4☐ Divorcad
12. Was Dacadant Evar in U.S. Armad Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:
13. Was Dacadant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*
14. Race - Amarican Indian, Black, Whita, atc. *Specify:* WHITE

15. Dacadant's Education *(Specify only highast grada complatad)*: Elamantary/Saconday (0-12); Collaga (1-4or 5+): 5+
16a. Dacadant's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratirad)*: SISTER OF NOTRE DAME
16b. Kind of Businass/Industry: TEACHER

17. Fathar's Nama *(First, Middla, Last)*: MICHAEL J. FITZGERALD
18. Mothar's Nama *(First, Middla, Maidan Surnama)*: ANNE McMAHON

19a. Informant's Nama/Ralationship *(Type, Print)*: SR. MARY ADELE WHITE
19b. Mailing Addrass *(Straat and Numbar or Rural Routa Numbar, City or Town, Stata, Zip Coda)*: 19 WINDWARD CT., THURMONT, MD. 21788

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Spacify)*
20b. Placa of Disposition *(Nama of camatary, crematory or othar placa)*: SISTER OF NOTRE DAME
Data: 5/17/97
20c. Location - City or Town, Stata: ELLICOTT CITY, MD.

21. Signatura of Funaral Sarvica Licansaa: John M. Skiles
22. Nama and Addrass of Facility: SKILES FUNERAL HOME, 210 W. MAIN ST., EMMITSBURG, MD. 21727

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only ona causa on aach lina.

Approximata Intarval Batwaan Onsat and Death

Immadiata Causa (Final disaasa or condition rasulting in daath)
a. Ischemic Cardiomyopathy — 5 yrs.
Dua to (or as a consaquanca of):
b. Atherosclerosis — 10 yrs
Dua to (or as a consaquanca of):
c. Hypertension — 20 yrs.
Dua to (or as a consaquanca of):
d.

Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that initiatad avants rasulting in daath) Last

Part II. **Othar significant conditions** contributing to daath but not rasulting in tha undarlying causa givan in Part I.

Osteoporosis.
Gastro esophageal reflux disease.
Peripheral Vascular Disease.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Ware autopsy findings availabla prior to complation of causa of daath? 1☐ Yas 2☐ No

25. Was casa rafarrad to medical examinar? 1☐ Yas 2☒ No
26. Placa of Death *(Check only ona)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA; Othar: 4☒ Nursing Home 5☐ Rasidance 6☐ Othar *(Specify)*
27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarmined
28a. Data of injury *(Month, Day Yaar)*
28b. Tima of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurrad
28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. *(Specify)*
28f. Location *(Straat and Numbar or Rural Routa Numbar, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1☒ **Certifying Physician**: To tha best of my knowladga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as statad. 2☐ **Medical Examiner**: On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar statad.
29b. Signatura and titla of cartifiar: Bonita J. Krempel-Portesso
29c. Licansa number: H44037
29d. Data signad *(Month, Day, Yaar)*: 13 MAY 1997
30. Nama and addrass of parson who complatad causa of daath (Itam 23a) (Type, Print): Bonita J. Krempel-Portesso 510 S. Seton Ave. Emmitsburg, MD 21727

State Registrar

31. Data filad *(Month, Day, Yaar)*: MAY 16 1997
32. Registrar's Signatura: Julia Thacker Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17257

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ruth Fike — Ruth C Fike

2. Data of Daath: Month May Day 19 Year 1997

3. Time of Death: 1:25 AM

4a. Facility Name *(If not Institution, give street and number)*: Dennett Road Nursing Home

4b. City, Town, or Location of Death: Oakland,

4c. County of Daath: Garrett

Funeral Director

5. Social Security Number: 236-32-6039

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 80 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan. 14, 1917

9. Birthplace *(State or Foreign Country)*: Garrett

To Be Completed by Funeral Director

Usual Rasidanca of Dacedant

10a. State: Md.

10b. County: Garrett

10c. City, Town or Location: Oa kland

10d. Inside City Limits: 1☒ Yas 2☐ No

10e. Straet and Numbar: 4265 Bradford Rd.

10f. Zip Coda: 21550

10g. Citizen of What Country?: USA

11. Maritel Status: 1☐ Never Marriad 2☒ Married 3☐ Widowed 4☐ Divorcad

12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No — If Yas, Giva Yaar or Dates:

13. Was Dacedant of Hispenic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yas 2☒ No *Specify:*

14. Race - American Indian, Black, White, atc. *Specify:* White

15. Decedent's Education *(Specify only highast grade compiatad)*: Elamantary/Secondary (0-12): 8th — Collaga (1-4or 5+):

16a. Dacedent's Usual Occupation *(Give kind of work dona during most of working lifa. DO NOT usa ratirad)*: Homemaker

16b. Kind of Busnass/Industry: Home

17. Fathar's Nama *(First, Middla, Last)*: Isaac Arnold

18. Mother's Nama *(First, Middla, Maidan Surname)*: Lula Fike

19a. Informant's Name/Ralationship *(Type, Print)*: Carl A. Simmons Son

19b. Mailing Address *(Street and Numbar or Rural Route Number, City or Town, Stata, Zip Coda)*: 3566 Bradford Rd. Oa kland, Md. 21550

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from State 4☐ Donetion 5☐ Othar *(Specify)*

20b. Place of Disposition *(Nama of camatary, cramatory or othar placa)*: Aurora, Cemetery — Dete: 5/22/97

20c. Location - City or Town, State: Aurora, WV.

21. Signatura of Funaral Servica Licansaa: Scott Hinkle

22. Name and Address of Facility: Hinkle Funeral Home Box 186 Davis, WV. 26260

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications thet causad the daath. Do not enter tha moda of dying, such as cardiac or respiretory arrast, shock, or haart failura. List only ona causa on aach lina.

Approximata Intarval Batween Onsat and Death

Immadiata Causa (Final disaasa or condition resulting in daath)
a. CARDIOPULMONARY FAILURE — 4 HR

Dua to (or as a consaquanca of):
b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE — 10 YEARS

Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disaasa or Injury that initiated avants resulting in daath) Last
Dua to (or as a consaquanca of):
c. TOBACCO — 50 YEARS

Dua to (or as a consaquanca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the undarlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy parformed? 1☐ Yes 2☒ No

24b. Wara autopsy findings aveileble prior to compiation of cause of daath? 1☐ Yas 2☐ No

25. Was casa refarrad to medical axaminar? 1☐ Yas 2☒ No

28. Placa of Death *(Check only ona)*: Hospital: 1☐ Inpatiant 2☒ ER/Outpatient 3☐ DOA — Othar: 4☒ Nursing Homa 5☐ Rasidance 8☐ Othar *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28e. Placa of Injury - At homa, farm, streat, factory, office building, atc. *(Specify)*

28f. Location *(Straat and Numbar or Rural Routa Numbar, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1☐ **Certifying Physician**: To tha bast of my knowladga, daath occurrad at tha time, data and placa, and dua to tha cause(s) and mannar as stated. 2☐ **Medical Examiner**: On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and placa, and dua to the cause(s) and mannar stated.

29b. Signature and title of certifier: M.D.

29c. Licansa number: D47309

29d. Date signed *(Month, Day, Yaar)*: 5.20.97

30. Nama and address of person who completed causa of daath (Item 23a) (Type, Print): B.K. MORRETT 311 N. FOURTH ST, OAKLAND, MARYLAND 21550

State Registrar

31. Data filad *(Month, Day, Yaar)*: JUN 02 1997

32. Registrar's Signature: Julia Davidson-Ronde

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17258

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Craig D. Fellows

2. Dete of Daeth — Month: 5 Dey: 7 Yeer: 97

3. Time of Deeth: 11:00 pm

4e. Feciility Name (If not institution, give street and number): University of MD Hospital

4b. City, Town, or Location of Deeth: Baltimore

4c. County of Deeth: Baltimore

Funeral Director

5. Social Security Number: 544-56-5533

6. Sex: 1☒M 2☐F

7. Age (In yrs. last birthday): 50 Yrs. — If Under 1 Yeer: Months / Deys — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 2/1/47

9. Birthpleca (State or Foraign Country): Oregon

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Carroll

10c. City, Town or Location: Manchester

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street end Number: 3104 Coachman Way

10f. Zip Code: 21102

10g. Citizen of Whet Country?: U.S.A.

11. Maritei Stetus: 1☐Never Merried 2☒Married 3☐Widowed 4☐Divorcad

12. Was Decedent Evar in U.S. Armed Forcas? 1☒Yes 2☐No If Yes, Give Year or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuben, Mexican, Puarto Rican, atc.) 1☐Yes 2☒No Specify:

14. Rece - Amarican Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 14 — College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Operation Manager

16b. Kind of Business/Industry: Spice

17. Fether's Neme (First, Middle, Last): Dean Claude Fellows

18. Mothar's Name (First, Middle, Melden Surname): Dolores Lorraine Forman

19a. Informent's Neme/Relationship (Type, Print): Merrilyn Fellows/wife

19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 3104 Coachman Way, Manchester, MD 21102

20a. Method of Disposition: 1☒Buriel 2☐Cremetion 3☐Removal from Stete 4☐Donetion 5☐Othar (Spacify)

20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece): Wicomico Memorial P. — Date: 5/13/97

20c. Location - City or Town, Stete: Salisbury

21. Signeture of Funeral Sarvica Licansee: Robert A Myers

22. Nema and Address of Facility: Myers Funeral Home, 91 Willis St. Westminster, MD21157

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet caused the death. Do not entar tha mode of dying, such as cardiac or respiratory arrast, shock, or heart feilure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediete Ceuse (Final disaasa or condition resulting in daath)
e. Pneumonitis — 2 days

Due to (or es a consequenca of):

Sequentielly list conditions, if eny, leeding to Immediete cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest
b. multiple myeloma — 1.5 years

Due to (or es e consequence of):

c.

Due to (or es a consequenca of):

d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Wes an autopsy performed? 1☐Yas 2☒No

24b. Ware autopsy findings availeble prior to completion of cause of deeth? 1☐Yas 2☐No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Wes case referred to medical exeminer? 1☐Yes 2☒No

26. Plece of Deeth (Check only one): Hospitel: 1☒Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☐Nursing Homa 5☐Residence 6☐Othar (Specify)

27. Menner of Deeth: 1☒Naturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury et Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒**Certifying Physicten:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2☐**Medical Examiner:** On the basis of exemination end/or Investigetion, in my opinion, deeth occurred at the time, dete end plece, end due to the ceuse(s) end menner steted.

29b. Signature and title of certifiar: Jose Zarzuela MD

29c. Licensa number: P 08549

29d. Dete signed (Month, Dey, Year): 5/7/97

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): Jose Zarzuela Univ. of MD Cancer Center

State Registrar

31. Deta filed (Month, Dey, Yeer): MAY 15 1997

32. Registrar's Signeture: Julia Anderson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RKD

97-2860-033

MYRTLE FLYTHE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items:23a part I,27 per MEO G-748 6/30/97

Certificate of Death

Reg. No. 97 17259

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MYRTLE FLYTHE

2. Deta of Deeth — Month: MAY; Dey: 24; Yeer: 1997

3. Time of Deeth: 4:35P.M.

4e. Feclity Nema *(If not institution, give streat end number)*: 2001 BORDER DRIVE

4b. City, Town, or Location of Death: FT.WASHINGTON

4c. County of Deeth: PRINCES GEORGES

Funeral Director

5. Social Security Number: 231-70-2005

6. Sax: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 47 Yrs.

If Under 1 Year — Months: ; Days:

If Under 24 Hrs. — Hours: ; Min.:

8. Dete of Birth *(Month, Dey, Yeer)*: OCTOBER 30, 49

9. Birthplece *(Stete or Foreign Country)*: NORTH CAROLINA

Usuel Residenca of Dacedent

10a. State: MD

10b. County: PRINCE GEORGES

10c. City, Town or Location: FORT WASHINGTON

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2001 BORDER DR.

10f. Zip Code: 20744

10g. Citizen of Whet Country?: UNITED STATES AMERICA

11. Maritei Stetus: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Datas:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.): 1☐ Yes 2☒ No *Specify:* X

14. Rece - Amarican Indian, Bleck, White, atc. *Specify:* BLACK

15. Decedent's Educetion *(Specify only highest grade completed)*: Elementary/Secondery (0-12); College (1-4or 5+): 6 YRS.

16e. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: PROJEST ANALYST

16b. Kind of Business/Industry: FED. GOVT.

17. Fether's Neme *(First, Middle, Last)*: CLYDE C. FLYTHE

18. Mother's Name *(First, Middle, Meidan Surneme)*: GEORGIA JOYNER

19e. Informent's Neme/Relationship *(Type, Print)*: GEORGIA FLYTHE

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 134 BUXTON AVE., NEW PORT NEWS, VA. 23607

20e. Metbod of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Nema of cemetery, cremetory or other piece)*: FLYTHE FAMILY CEMETERY

Dete: 5/30/97

20c. Location - City or Town, Stete: CONWAY, N.C.

21. Signature of Funeral Sarvice Licensee: Jack B. Jenkins

22. Name end Addrass of Fecility: JOHNSON & JENKINS INC. 716 KENNEDY ST. N.W. W.D.C. 20011

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not anter the moda of dying, such as cardiac or respiretory errast, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset end Deeth

Immediate Ceuse (Final diseese or condition resulting in deeth): e. SEIZURE DISORDER

Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to Immediete ceuse. Enter Underlying Cause (Disease or Injury thet Initiated events resulting in daath) Last

b. Dua to (or es e consequence of):

c. Dua to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying ceuse given in Part I.

23b. **Did tobecco use contributa to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Was en eutopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings availeble prior to completion of ceuse of deeth? 1☒ Yes 2☐ No

25. Wes cese referred to medical exeminer? 1☒ Yes 2☐ No

26. Plece of Deeth *(Check only one)*: Hospital: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Yeer)*

28b. Time of Injury

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Streat end Number or Rurel Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☐ **Certifying Physicien:** To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) and manner as stated. 2☒ **Medical Examiner:** On the besis of exeminetion end/or Investigetion, in my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) end manner stated.

29b. Signatura and title of certifier: Stephen S. Radentz, MP

29c. License number: O.C.M.E.

29d. Date signed *(Month, Dey, Yeer)*: MAY 25,1997

30. Neme end eddress of person who completed ceuse of deeth (Item 29a) (Type, Print): Stephen S. Radentz MP 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 30 1997

32. Registrer's Signature: John Thompson Cochran

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is merkic other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17260

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): PERCY FERGUSON
2. Data of Death Month: MAY Day: 15 Year: 1997
3. Tima of Death: 09:30 AM
4a. Facility Name (If not institution, give straet and number): SOUTHERN MARYLAND HOSPITAL
4b. City, Town, or Location of Death: CLINTON
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 577-14-4472
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 101 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAY 27, 1895
9. Birthplace (State or Foreign Country): SOUTH CAROLINA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: PRINCE GEORGES
10c. City, Town or Location: UPPER MARLBORO
10d. Inside City Limits: 1 [X] Yas 2 [ ] No
10e. Street and Number: 309 RIDGELY ST.
10f. Zip Code: 20774
10g. Citizen of What Country?: UNITED STATES AMERICA

11. Marital Status: 1 [ ] Nevar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yas 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6th GRADE; College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): unknown
16b. Kind of Business/Industry: unknown

17. Father's Name (First, Middla, Last): ALFRED FERGUSON
18. Mother's Name (First, Middla, Maiden Surname): unknown

19a. Informant's Neme/Relationship (Type, Print): CHRISTINE A. JOHNSON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 309 RIDGELY ST. UPPER MARLBORO, MD. 20774

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): HARMONY MEMORIAL PARK Data: 5/20/97
20c. Location - City or Town, State: LANDOVER, MD.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: JOHNSON & JENKINS INC. 716 KENNEDY ST. N.W. W.D.C. 20011

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not antar the moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death): e. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or es a consequence of):

c. Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause givan in Part I.

23b. Did tobacco uae contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Wara autopsy findings available prior to completion of causa of death? 1 [ ] Yes 2 [ ] No

25. Was casa referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, dete end place, end due to the cause(s) and manner as stated. 2 [X] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. Licensa number: DEPUTY MEDICAL EXAMINER D 33954
29d. Date signed (Month, Day, Year): MAY 15, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARIO F. GOLIA JR MD 3001 HOSPITAL DRIVE, CHEVERLY MARYLAND 20785

State Registrar

31. Date filed (Month, Day, Year): MAY 20 1997
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 17261

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Grace A. Fitzgerald
2. Date of Death Month / Day / Year: May 18 1997
3. Time of Death: 5:00 PM
4a. Facility Name *(If not institution, give street and number)*: Doctor's Community Hospital
4b. City, Town, or Location of Death: Lanham
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577-30-9475
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Nov. 5, 1916
9. Birthplace *(State or Foreign Country)*: Ohio

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Riverdale
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 5911 62nd Avenue
10f. Zip Code: 20737
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: John Violette
18. Mother's Name *(First, Middle, Maiden Surname)*: Rose Baker

19a. Informant's Name/Relationship *(Type, Print)*: William T. Fitzgerald - Spouse
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5911 62nd Avenue, Riverdale, Maryland 20737

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Resurrection Cemetery
Date: 05/22/97
20c. Location - City or Town, State: Clinton, Maryland

21. Signature of Funeral Service Licensee: Cathy Jean Duty
22. Name and Address of Facility: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. PART I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Intracerebral hemorrhage — 6 Days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Sigh MD
29c. License number: D45660
29d. Date signed *(Month, Day, Year)*: 5-19-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): 3066 Mitchellville Rd, Bowie MD 20716

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 22 1997
32. Registrar's Signature: [signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

GRACE FITZGERALD

15

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17262

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Laura Helen Forsythe
2. Date of Death Month Day Year: May 22, 1997
3. Time of Death: 0525
4a. Facility Name *(If not institution, give street and number)*: Washington County Hospital
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 215-36-6601
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 90 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: March 22, 1907
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 130 Broadway
10f. Zip Code: 21740
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 — College (1-4 or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: nursing assistant
16b. Kind of Business/Industry: hospital

17. Father's Name *(First, Middle, Last)*: Maurice Nelson Arnsparger
18. Mother's Name *(First, Middle, Maiden Surname)*: Laura Lee Hammond

19a. Informant's Name/Relationship *(Type, Print)*: Charles H. Forsythe
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1680 langley Drive Hagerstown, Maryland 21740

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Rose Hill Cemetery — Date: 5/24/97
20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Gerald N. Minnich
22. Name and Address of Facility: Gerald N. Minnich Funeral Home — 305 N. Potomac Street Hagerstown, Maryland 21740

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE — 10 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
cor pulmonale

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John P. Reed
29c. License number: D43590
29d. Date signed *(Month, Day, Year)*: 5-23-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 22911 Jefferson BLVD SMITHSBURG MD 21783, JOHN P. REED

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 27 1997
32. Registrar's Signature: John Shuckerow Rachel

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17263

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Lest)*: Harry Rosario Fava

2. Dete of Daath — Month: May; Dey: 17; Yaer: 1997

3. Tima of Deeth: 7:56 a.m.

4a. Fecility Name *(If not institution, giva street and number)*: Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Sociel Security Number: 220-12-7931

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. lest birthday)*: 78 Yrs.

If Undar 1 Yaar — Months: ; Deys:

If Under 24 Hrs. — Hours: ; Min.:

8. Data of Birth *(Month, Dey, Yaar)*: Jan. 11, 1919

9. Birthplace *(Stete or Foraign Country)*: Maryland

Usuel Residence of Decedent

10e. Stete: Maryland

10b. County: Howard

10c. City, Town or Location: Mount Airy

10d. Insida City Limits: 1☐ Yas 2☒ No

10e. Street end Number: 725 Long Corner Road

10f. Zip Code: 21771

10g. Citizan of Whet Country?: American

11. Maritel Stetus: 1☐ Navar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedant Evar in U.S. Armed Forces?: 1☒ Yes 2☐ No — If Yes, Give Yeer or Detas: WWII

13. Wes Dacedenf of Hispenic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Reca - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest greda completed)*

Elamantery/Secondery (0-12): 8

College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Giva kind of work done during most of working life. DO NOT usa ratired)*: Barber

16b. Kind of Business/Industry: Barbering

17. Father's Name *(First, Middle, Last)*: Dominic Fava

18. Mothar's Nama *(First, Middle, Maiden Surnama)*: Sarah Guerico

19a. Informent's Neme/Reletionship *(Type, Print)*: Carolyn J. Kerzel - Daughter

19b. Melling Addrass *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 861 Snow Fall Way, Westminster, Maryland 21157

20e. Mathod of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Ramoval from State 4☐ Donetion 5☐ Othar *(Spacify)*

20b. Place of Disposition *(Name of cemetery, cremetory or othar place)*: Poplar Springs Meth. Cem.

Data: 5/20/97

20c. Location - City or Town, Stete: Mount Airy, Maryland

21. Signature of Funerai Servica Licensee: Olin L. Molesworth

22. Name end Address of Fecility: Olin L. Molesworth, P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Entar tha disaase, or complications that caused the death. Do not anter fha mode of dying, such es cardiac or respiretory arrest, shock, or heert failura. List only one cause on eech line.

Approximeta Interval Between Onset end Deeth

Immediete Ceuse (Finel disease or condition resulting in daath)

a. Acute Myelogenous Leukemia — Due to (or es e consequenca of): — 1 Month

Sequentielly list conditions, if eny, laading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Lest

b. Dua to (or as e consequenca of):

c. Dua to (or es e consaquance of):

d.

Part II. **Other elgnificent conditions** contributing to death but not rasulting in the underlying causa given in Pert I.

Hyperviscosity

Atrial Fibrillation

23b. Did tobecco use contribute to the ceuse of deeth? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Wara autopsy findings availabla prior to compiation of cause of death? 1☐ Yes 2☐ No

25. Was casa referred to medical exeminer? 1☐ Yas 2☑ No

26. Placa of Death *(Check only one)*: Hospital: 1☑ Inpatiant 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residanca 6☐ Othar *(Specify)*

27. Manner of Deeth: 1☑ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding investigetion 6☐ Could not be determined

28e. Data of Injury *(Month, Day Year)*:

28b. Tima of Injury:

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Placa of Injury - At home, farm, streat, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that tha death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To tha bast of my knowledge, deeth occurred at tha tima, date end pleca, end due to the ceusa(s) end manner as stated. 2☐ **Medical Exeminer:** On the basis of axamination end/or investigetion, in my opinion, daath occurred at the time, date end placa, end dua to tha causa(s) and manner stated.

29b. Signeture end titla of certifier: Eugene B. Casagrande

29c. License number: 040307

29d. Dete signed *(Month, Day, Year)*: 05/17/97

30. Neme end address of person who completed cause of deeth (Item 23e) (Typa, Print): Eugene B. Casagrande, M.D. Parkview Medical Center, Frederick, Maryland 21701

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 19 1997

32. Registrer's Signatura: Lisa Davidson-Randall

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17264

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Frances Fahey

2. Data of Death: Month May Day 16, Yaar 1997

3. Tima of Death: 7:30 p.m.

4a. Facility Nama (If not institution, giva street and number): Devlin Manor Nursing Home

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 214-05-8781

6. Sax: 1☐ M 2☒ F

7. Aga (In yrs. last birthday): 91 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Yaar): May 12, 1906

9. Birthplace (Stata or Foraign Country): MD

Usual Rasidance of Decedant

10a. Stata: MD

10b. County: Allegany

10c. City, Town or Location: Cumberland

10d. Insida City Limits: 1☒ Yas 2☐ No

10e. Street and Number: 1 Baltimore Street

10f. Zip Coda: 21502

10g. Citizan of What Country?: USA

11. Marital Status: 1☒ Nevar Married 2☐ Married 3☐ Widowad 4☐ Divorcad

12. Was Dacadant Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 1☐ Yas 2☒ No Specify:

14. Raca - American Indian, Black, Whita, etc. Specify: white

15. Decedant's Education (Specify only highast grada complatad)

Elamantary/Saconday (0-12): 12

Collaga (1-4or 5+):

16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratirad): Asst. Office Supervisor

16b. Kind of Businass/Industry: Prudential Life Ins.

17. Fathar's Nama (First, Middla, Last): Michael Fahey

18. Mothar's Nama (First, Middla, Maidan Surnama): Bridget (Carney)

19a. Informant's Name/Ralationship (Type, Print): Eileen Carroll - cousin

19b. Mailing Address (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Code): 703 Montgomery Avenue Cumberland MD 21502

20a. Mathod of Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)

20b. Place of Disposition (Nama of camatary, cramatory or othar placa): St. Peter's Cemetery

Data: 05/19

20c. Location - City or Town, Stata: Westernport, MD

21. Signatura of Funaral Service Licensaa: James F Scarpelli

22. Nama and Address of Facility: Scarpelli Funeral Home Cumberland, MD 21502

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Entar tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina.

Approximata Intarval Batwaan Onsat and Death

Immadiata Causa (Final disaasa or condition rasulting in daath): a. CEREBROVASCULAR ACCIDENT — 1 yr.

Dua to (or as a consaquanca of):

Saquantially list conditions, if any, laading to immadiata cause. Entar Undarlying Cause (Disaasa or Injury that initiatad avants rasulting in daath) Last:

b.

Dua to (or as a consaquanca of):

c.

Dua to (or as a consaquanca of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.: HYPOTHYROIDISM, ATRIAL FIBRILLATION

23b. Did tobacco use contribute to the cause of death? 1☐ Yas 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to completion of cause of death? 1☐ Yas 2☒ No

25. Was casa rafarrad to medical examinar? 1☐ Yas 2☒ No

28. Placa of Death (Check only ona)

Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA

Other: 4☒ Nursing Homa 5☐ Rasidance 6☐ Othar (Specify)

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending Invastigation 6☐ Could not be datarmined

28a. Data of Injury (Month, Day Yaar)

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurrad

28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifiar (Check only one): 1☒ **Certifying Physician:** To tha best of my knowladga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and manner as atatad. 2☐ **Madical Examinar:** On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha causaa(s) and mannar statad.

29b. Signatura and titla of certifiar: DBS MD.

29c. Licansa number: D 23334

29d. Data signad (Month, Day, Yaar): 19th MAY 1997

30. Nama and addrass of parson who compatad causa of daath (Itam 23a) (Type, Print): Dinesh Shah 625 Kent Avenue Cumberland MD 21502

State Registrar

31. Data filad (Month, Day, Yaar): MAY 21 1997

32. Registrar's Signatura: John Hunter Randall

DHMH 16 Rav 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

NLS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17265

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Emanuel J Fontana
2. Date of Death (Month, Day, Year): May 23, 1997
3. Time of Death: 9:35 AM
4a. Facility Name (If not institution, give street and number): Southern Maryland Hospital
4b. City, Town, or Location of Death: Clinton
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 578-03-2130
6. Sex: XX M 2☐ F
7. Age (In yrs. last birthday): 80 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept 16, 1916
9. Birthplace (State or Foreign Country): Washington DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Upper Marlboro
10d. Inside City Limits: 1☐ Yes XX No
10e. Street and Number: 10710 Tyrone Drive
10f. Zip Code: 20772
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married XX 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? XX Yes 2☐ No — If Yes, Give Year or Dates: 1944 1946
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☐ XX No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Lithographer
16b. Kind of Business/Industry: Business Owner

17. Father's Name (First, Middle, Last): Gabriel Fontana
18. Mother's Name (First, Middle, Maiden Surname): Alvira Mastrolacasa

19a. Informant's Name/Relationship (Type, Print): Charlotte B. Fontana
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10710 Tyrone Drive, Upper Marlboro, Md 20772

20a. Method of Disposition: 1 XX Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): Resurrection Cemetery — Date: May 27, 1997
20c. Location - City or Town, State: Clinton, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Lee Funeral Home, Inc 6633 Old Alexandria Ferry Rd, Clinton, Md 20735

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Chronic obstructive pulmonary disease
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Coronary artery disease
Due to (or as a consequence of):
c. Gall bladder infection
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: cholelithiasis S/P cholecystectomy

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 8☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John Patterson, MD.
29c. License number: D19633
29d. Date signed (Month, Day, Year): 5/23/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John C. Patterson, M.D. 7501 Surratts Rd #201A Clinton Md 20735

State Registrar

31. Date filed (Month, Day, Year): MAY 27 1997
32. Registrar's Signature: Julia Davidson Randall

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17266

Gladys Faulkner SS# 221-18-1890

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Gladys J. Faulkner
2. Date of Death Month Dey Year: May 12, 1997
3. Time of Death: 0915
4e. Facility Neme (If not institution, give street end number): PENINSULA REGIONAL MEDICAL CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 221-18-1890
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. lest birthday): 84 Yrs.
If Under 1 Year: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): Dec. 27, 1912
9. Birthplece (Stete or Foreign Country): Delaware

To Be Completed by Funeral Director

Usuel Residence of Decedent

10e. State: Delaware
10b. County: Sussex
10c. City, Town or Location: Laurel
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 127 Evergreen Drive
10f. Zip Code: 19956
10g. Citizen of Whet Country?: U.S.A.
11. Maritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Reca - American Indien, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): College (1-4or 5+): 3
16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Registered Nurse
16b. Kind of Business/Industry: Doctors Office
17. Fether's Neme (First, Middle, Last): Harry L. Ralph
18. Mother's Neme (First, Middle, Maiden Surneme): Fannie Wiley Ralph
19e. Informent's Neme/Reletionship (Type, Print): Julie F. Slatcher/Daughter
19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 127 Evergreen Drive Laurel, DE 19956
20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)
20b. Plece of Disposition (Neme of cemetery, cremetory or other piece): Odd Fellows Cemetery
Dete: 5-15-97
20c. Locetion - City or Town, State: Laurel, Delaware
21. Signeture of Funeral Service Licensee: ▶ Holly S. Hannigan
22. Neme end Address of Fecility: Short Funeral Home, Inc. 700 West Street Laurel, DE 19956

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the diseese, or complicetions that caused the death. Do not enter the mode of dying, such es cardiec or respiretory erresl, shock, or heart failure. List only one cause on eech line.

Approximete Intervel Between Onset end Deeth

Immediete Cause (Finel diseese or condition resulting in deeth)
e. Severe G.I. Bleeding. — Hours.

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or Injury thet Initieted events resulting in deeth) Lest
b.

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Pert I.

Severe Coronary Artery Disease; Congestive Heart Failure
Severe Hemolytic Anemia.
Hyper Kalemia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☑ No

26. Plece of Death (Check only one): Hospital: 1☑ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Menner of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Locetion (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, dete end plece, and due to the cause(s) end menner steted.

29b. Signeture end title of certifier: ▶ Joseph Cruickshank MD
29c. License number: D44069
29d. Dete signed (Month, Dey, Year): 5-12-97

30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print): Joseph Cruickshank MD 106 Milford St Ste 104 Salisbury, MD 21804

State Registrar

31. Dete filed (Month, Dey, Year): MAY 15 1997
32. Registrer's Signeture: Julia Henderson Randall

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17267

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Frizzell J. Gardner

2. Date of Death (Month, Day, Year): May 17, 1997

3. Time of Death: 8:15 a.

4a. Facility Name *(If not institution, give street and number)*: Hyattsville Manor Nursing Home

4b. City, Town, or Location of Death: Hyattsville

4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 219-74-5119

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 38 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct. 12, 1958

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 217 Frederick Avenue

10f. Zip Code: 20850

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Presser

16b. Kind of Business/Industry: Dry Cleaning Co.

17. Father's Name *(First, Middle, Last)*: Frizzell Gardner

18. Mother's Name *(First, Middle, Maiden Surname)*: Nebraska Cooper

19a. Informant's Name/Relationship *(Type, Print)*: Bernadette S. Moore (Sister)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1801 E. Lamley St. Baltimore, MD 21231

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St. Mary's Cemetery | Date: 5/20

20c. Location - City or Town, State: Rockville, MD

21. Signature of Funeral Service Licensee: Bruce A. Snowden

22. Name and Address of Facility: SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. CARDIO Respiratory Failure

Due to (or as a consequence of):

b. Adult Immuno-deficiency Syndrome

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Cerebro VASCular Accident

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*: N/A

28b. Time of Injury: M

28c. Injury at Work? 1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Gita K. Shah MD

29c. License number: D20251

29d. Date signed *(Month, Day, Year)*: 5/19/1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 7350 Van Dusen Rd. Suit 220 Laurel MD 20707

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 20 1997

32. Registrar's Signature: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17268

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RICHARD BLAIR GIARTH
2. Data of Death Month: MAY Day: 19 Year: 1997
3. Time of Death: 1137
4a. Facility Name (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 220-56-7139
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 46 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 11, 1950
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Germantown
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 18708 White Sands Drive
10f. Zip Code: 20874
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4 or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Machinist
16b. Kind of Business/Industry: Engineering

17. Father's Name (First, Middle, Last): Richard Clair Giarth
18. Mother's Name (First, Middle, Maiden Surname): Margaret Ann Cheri

19a. Informant's Name/Relationship (Type, Print): Jonni Rose Giarth (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 18708 White Sands Drive, Germantown, MD 20874

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): George Washington Cemetery
Date: 5/23/97
20c. Location - City or Town, State: Adelphi, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

CP

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. SEPTIC SHOCK — 10 DAYS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

RESPIRATORY FAILURE

RENAL CELL CARCINOMA

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] CRITICAL CARE CONSULTANT
29c. License number: D30112
29d. Date signed (Month, Day, Year): MAY 19 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): VIRENDRA K. SAXENA MD 7100 DEER CROSSING COURT BETHESDA MD 20817

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): MAY 21 1997
32. Registrar's Signature: [signature]

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17269

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JOAN SONIA GREENBERG
2. Date of Death — Month: MAY; Day: 15; Year: 1997
3. Time of Death: 10:45 AM
4a. Facility Name *(If not Institution, give street and number)*: MONTGOMERY GENERAL HOSPITAL
4b. City, Town, or Location of Death: OLNEY
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 142-30-1571
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 57 Yrs.
If Under 1 Year — Months: ; Days:
If Under 24 Hrs. — Hours: ; Min.:
8. Date of Birth *(Month, Day, Year)*: August 27, 1939
9. Birthplace *(State or Foreign Country)*: New Jersey

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Olney
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 17800 Howe Drive
10f. Zip Code: 20832-2227
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*
Elementary/Secondary (0-12): 12
College (1-4 or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: legal secretary
16b. Kind of Business/Industry: law firm

17. Father's Name *(First, Middle, Last)*: Leo Brodie
18. Mother's Name *(First, Middle, Maiden Surname)*: Sara Bloch

19a. Informant's Name/Relationship *(Type, Print)*: Glenn Allen Greenberg
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1842 Cherokee Drive, Apt. 102, Hollywood, CA 90028

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: U.S.U.H.S.
Date: 5-16-97
20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: Carol A Dellm
22. Name and Address of Facility: Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 20910

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. LIVER FAILURE	4 DAYS
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. PRIMARY BILIARY CIRRHOSIS	5 YEARS
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*
Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: William Stern
29c. License number: D21865
29d. Date signed *(Month, Day, Year)*: MAY 15 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): WILLIAM R. STERN, M.D., 14816 PHYSICIANS LANE, ROCKVILLE, MD 20850

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 19 1997
32. Registrar's Signature: Gina Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17270

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Roy A. Greenfield
2. Data of Death Month/Day/Year: 05/15/97
3. Time of Death: 3pm
4a. Facility Name (If not institution, give street and number): Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-03-1888
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 7, 1915
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 8201 - 16th Street
10f. Zip Code: 20910
10g. Citizen of What Country?: United States

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: 1943-44
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Administrator
16b. Kind of Business/Industry: U.S. Government

17. Father's Name (First, Middle, Last): Eugene Greenfield
18. Mother's Name (First, Middle, Maiden Surname): Roy Pinkard

19a. Informant's Name/Relationship (Type, Print): Laroy Coleman, nephew
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9612 Sunset Drive, Potomac, Maryland 20850

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Olivet Cemetery
Date: 5/24/97
20c. Location - City or Town, State: Washington, D.C.

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W., Washington, D.C.

To Be Completed by Funeral Director

CP

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. ACUTE/CHRONIC RENAL FAILURE — W'KS TO MOS.

Due to (or as a consequence of):
b. MASSIVE GASTRO-INTESTINL BLEED — DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. ACUTE MYOCARDIAL INFARCT — DAYS TO WKS
Due to (or as a consequence of):
d. ARTERIOSCLEROTIC HEART DISEASE — YRS.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
DIABETES MELLITUS

23b. **Did tobacco use contribute to the cause of death?** 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Albert H. Grollman MD.
29c. License number: D02404-MD
29d. Data signed (Month, Day, Year): MAY 15, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ALBERT H. GROLLMAN, MD. 10801 LOCKWOOD RD. SILVER SPRING, MD. 20901

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

AG

State Registrar

31. Date filed (Month, Day, Year): MAY 15, 1997
32. Registrar's Signature: ▶

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17271

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: DEWEY GIBSON

2. Date of Death Month / Day / Year: may 17, 1997

3. Time of Death: 9:30 AM

4a. Facility Name *(If not institution, give street and number)*: WATERVIEW HEALTHCARE CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 237-03-7855

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 5,1912

9. Birthplace *(State or Foreign Country)*: Unknown

Usual Residence of Decedent

10a. State: Maryland

10b. County: Wicomico

10c. City, Town or Location: Salisbury

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 302 E. Vine St.

10f. Zip Code: 21801

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Nevar Merried 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yas or No- if Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - Amarican Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): UNK; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work dona during most of working life. DO NOT use retired)*: UNK

16b. Kind of Business/Industry: UNK

17. Father's Name *(First, Middle, Lest)*: Unknown

18. Mother's Nema *(First, Middle, Meiden Surneme)*: Unknown

19a. Informent's Neme/Reletionship *(Type, Print)*: Wanda G. Kurdian/Daughter

19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 2704 Griffin Rd., Rural Hall, NC 27045

20a. Method of Disposition: 1☐ Buriel 2☒ Cremation 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Spacify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Salisbury Crematory

Dete: 5/23/97

20c. Locetion - City or Town, Stete: Salisbury, MD

21. Signature of Funeral Service Licensee: David A. Thompson Malosi

22. Name end Address of Facility: Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

23a. Part1. Enter tha disaese, or compltcations that caused the death. Do not enter the mode of dying, such as cerdiac or raspiratory arrest, shock, or heart feilura. List only one ceuse on aech line.

Approximeta Interval Between Onset end Deeth

Immedete Ceuse (Finel disaase or condition resulting in death)

e. ATHEROSCLEROTIC CARDIOVASCU >10YR.

Due to (or es e consequance of): -LAR. DISEASE

Sequantially list conditions, if eny, leeding to immedete cause. Enter Underlying Ceusa (Diseese or injury thet initieted events resulting in deeth) Lest

b. COPD >10YR.

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: DEMENTIA.

23b. **Did tobacco uee contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings availeble prior to completion of cause of deeth? 1☐ Yes 2☐ No N/A.

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Straet end Number or Rurel Routa Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Phyeician**: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Exeminer**: On the besis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end pleca, end due to the cause(s) end menner stated.

29b. Signature end title of certifier: Mukesh Moondra MD

29c. License number: D32014

29d. Data signed *(Month, Day, Year)*: 5-17-97

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): MAHESH MOONDRA 547E RIVERSIDE DRIVE SALISBURY MD 21801

State Registrar

31. Dete filed *(Month, Day, Year)*: MAY 21 1997

32. Registrar's Signeture: Julia Davidson Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17272

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: DONALD LEWIS GARDE

2. Date of Death Month / Day / Year: MAY 24 1997

3. Time of Death: 1828

4a. Facility Name *(If not institution, give street and number)*: SACRED HEART HOSPITAL

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 220-74-8344

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 36 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sept 12 1960

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Md

10b. County: Allegany

10c. City, Town or Location: Lonaconing

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: Lana Lu Apartments,Main St.

10f. Zip Code: 21539

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: US Army

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): Unknown | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Welldriller

16b. Kind of Business/Industry: H&H Bunker WellDrill

17. Father's Name *(First, Middle, Last)*: Roland Louis Garde

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Bush

19a. Informant's Name/Relationship *(Type, Print)*: Mary Bosley

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 23526 Middle St. Barton, Md. 21521

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Laurel Hill Cemetery

Date: 5/28/97

20c. Location - City or Town, State: Moscow, Md.

21. Signature of Funeral Service Licensee: Wayne Boal

22. Name and Address of Facility: Boal Funeral Home 111 Church St,Westernport,Md. 21562

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ASPIRATION GASTRIC CONTENTS — 30 MINUTES

Due to (or as a consequence of):

MEDICATION OVERDOSE — 9 HOURS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last

b. Due to (or as a consequence of): ADJUSTMENT DISORDER — YRS

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*: 5/24/97

28b. Time of Injury: AM

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred: SUB OVERDOSED ON MEDICATION

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: RESIDENCE

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: 40 MAIN ST LONACONING MD 21539

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: DPTY MED EX

29c. License number: D 09157

29d. Date signed *(Month, Day, Year)*: MAY 24 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PAUL SNOW, M.D. 124 W 3RD ST CUMB MD 21502

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 27 1997

32. Registrar's Signature: Lori Strickler-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

6

4IVA 1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17273

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JOHN JEFFERSON GILBERT

2. Date of Death Month: MAY Day: 26 Year: 1997

3. Time of Death: 6:50 AM

4a. Facility Name *(If not institution, give street and number)*: Suburban Hosptial

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery County

Funeral Director

5. Social Security Number: 224-12-3172

6. Sex: [X] 1 M [ ] 2 F

7. Age *(In yrs. last birthday)*: 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 11, 1912

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery County

10c. City, Town or Location: Takoma Park

10d. Inside City Limits: [X] 1 Yes [ ] 2 No

10e. Street and Number: 7620 Maple Avenue #636

10f. Zip Code: 20912

10g. Citizen of What Country?: United States of America

11. Marital Status: [ ] 1 Never Married [X] 2 Married [ ] 3 Widowed [ ] 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? [X] 1 Yes [ ] 2 No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) [ ] 1 Yes [X] 2 No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Building Contractor

16b. Kind of Business/Industry: Building/Construction

17. Father's Name *(First, Middle, Last)*: John Wesley Gilbert

18. Mother's Name *(First, Middle, Maiden Surname)*: Elizabeth Johnson

19a. Informant's Name/Relationship *(Type, Print)*: John E. Gilbert /Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7620 Maple Avenue #636, Takoma Park, Maryland 20912

20a. Method of Disposition: [X] 1 Burial [ ] 2 Cremation [ ] 3 Removal from State [ ] 4 Donation [ ] 5 Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Oakwood Cemetery

Date: May 31, 1997

20c. Location - City or Town, State: Charlottesville, Virginia

21. Signature of Funeral Service Licensee: John W. Dove

22. Name and Address of Facility: J. F. Bell Funeral Home, 108 6th Street, N.W., Charlottesville, Virginia

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Congestive Heart Failure — days

Due to (or as a consequence of):
b. atherosclerosis — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Cancer of Colon
Cerebrovascular Accident

23b. Did tobacco use contribute to the cause of death? [ ] 1 Yes [ ] 2 No [ ] 3 Probably [X] 4 Unknown

24a. Was an autopsy performed? [ ] 1 Yes [X] 2 No

24b. Were autopsy findings available prior to completion of cause of death? [ ] 1 Yes [ ] 2 No

25. Was case referred to medical examiner? [X] 1 Yes [ ] 2 No

26. Place of Death *(Check only one)*: Hospital: [ ] 1 Inpatient [ ] 2 ER/Outpatient [ ] 3 DOA | Other: [X] 4 Nursing Home [ ] 5 Residence [ ] 8 Other *(Specify)*

27. Manner of Death: [X] 1 Natural [ ] 2 Accident [ ] 3 Suicide [ ] 4 Homicide [ ] 5 Pending Investigation [ ] 6 Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? [ ] 1 Yes [ ] 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: [X] 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. [ ] 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Joel Schulman M.D

29c. License number: D20516

29d. Date signed *(Month, Day, Year)*: May 26, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Joel Schulman 9410 D N Georgetown Rd Rockville Md 20854

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 30 1997

32. Registrar's Signature: Julia Davidson Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17274

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William A. Glynn
2. Date of Death (Month, Day, Year): May 25, 1997
3. Time of Death: 7:15 AM
4a. Facility Name (If not Institution, give street and number): Bedford Court
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 328-10-1766
6. Sex: XX M 2☐ F
7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 26, 1909
9. Birthplace (State or Foreign Country): Illinois

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Potomac
10d. Inside City Limits: 1☐ Yes XX No
10e. Street and Number: 7719 Heatherton Lane
10f. Zip Code: 20854
10g. Citizen of What Country?: United States of America

11. Marital Status: 1☐ Never Married 2☐ Married XX 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2XX No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2XX No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Wood Pattern Maker
16b. Kind of Business/Industry: Pattern Making

17. Father's Name (First, Middle, Last): Arthur J. Glynn
18. Mother's Name (First, Middle, Maiden Surname): Sylvia Fay Graham

19a. Informant's Name/Relationship (Type, Print): Sally Leffew - Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7719 Heatherton Lane Potomac, MD 20854

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Queen of Heaven Cemetery | Date: 5/29/97
20c. Location - City or Town, State: Hillside, IL
21. Signature of Funeral Service Licensee: #M00690 Howard A. Causey
22. Name and Address of Facility: Countryside Funeral Home 1640 Greenmeadow Streamwood, IL 60107

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	INANITION	weeks
Due to (or as a consequence of):	PARKINSON Disease	Years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.		
Due to (or as a consequence of):	Parkinson Dementia	Years.
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Robert A Knitzer MD
29c. License number: D37930
29d. Date signed (Month, Day, Year): May 27, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROBERT A KNITZER MD 1811 Prince Philip Dr #312 Olney MD 20832

State Registrar

31. Date filed (Month, Day, Year): MAY 30 1997
32. Registrar's Signature: Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Amend# 1 5-28-97 cms

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17275

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Robert Edgar Gilbertson, Sr.

2. Data of Death Month Day Year: May 25, 1997

3. Time of Death: 13:15

4a. Facility Name *(If not institution, give street and number)*: Calvert Memorial Hospital

4b. City, Town, or Location of Death: Prince Frederick

4c. County of Death: Calvert

Funeral Director

5. Social Security Number: 217-18-2235

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 75 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: July 31 1921

9. Birthplaca *(Stata or Foraign Country)*: Washington, D.C.

Usual Rasidanca of Dacedant

10a. Stata: MD

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Insida City Limits: 1 [ ] Yas 2 [X] No

10e. Street and Numbar: 932 Mastline Drive

10f. Zip Coda: 21401

10g. Citizan of Whaf Countfy?: United States

11. Marital Status: 1 [ ] Navar Marriad 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Dacedant Evar in U.S. Armed Forcas? 1 [ ] Yas 2 [X] No If Yas, Giva Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 [ ] Yas 2 [X] No *Specify:*

14. Race - Amarican Indian, Black, Whita, atc. *Specify:* White

15. Decedant's Education *(Specify only highast grada completad)*: Elamantary/Secondary (0-12): Collega (1-4or 5+): 4

16a. Decedant's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratired)*: Soil Conservation Service of Agriculture

16b. Kind of Businass/Industry: Department

17. Fathar's Nama *(First, Middla, Last)*: Henry W. Gilbertson, Sr.

18. Mothar's Nama *(First, Middla, Maidan Surnama)*: Maude Hubbard

19a. Informant's Name/Ralationship *(Typa, Print)*: Betty M. Gilbertson (Wife)

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 932 Mastline Drive Annapolis, Maryland 21401

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Othar *(Specify)*

20b. Place of Disposition *(Nama of cematary, cramatory or othar place)*: Davidsonville United Methodist Church Cemetery Date: May 29, 1997

20c. Location - City or Town, Stata: Davidsonville, MD

21. Signatura of Funaral Sarvica Licensaa: James M. Taylor

22. Nama and Address of Facility: John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List *only* ona causa on aach lina.

Approximata Intarval Batwaan Onsat and Death

Immediate Cause (Final disease or condition resulting in death):
a. Respratory Failure 2° to Pnuemonia

Due to (or as a consequance of):
b. Severe Parkinsons Disease

Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disaasa or injury that initiatad avants rasulting in daath) Last

Dua to (or as a consaquanca of):
c.

Dua to (or as a consaquanca of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undariying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performad? 1 [ ] Yas 2 [X] No

24b. Wara autopsy findings available prior to complation of causa of daath? 1 [ ] Yas 2 [ ] No

25. Was casa rafarrad to madical examinar? 1 [ ] Yas 2 [X] No

26. Placa of Death *(Check only ona)*: Hospital: 1 [X] Inpatiant 2 [ ] ER/Outpatiant 3 [ ] DOA Othar: 4 [ ] Nursing Homa 5 [ ] Rasidance 6 [ ] Othar *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accidant 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Panding invasfigation 6 [ ] Could not be datarmined

28a. Data of Injury *(Month, Day Yaar)*

28b. Tima of Injury M

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Dascribe how injury occurred

28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. *(Specify)*

28f. Location *(Straat and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1 [X] **Certifying Physician**: To tha bast of my knowladga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2 [ ] **Medical Examiner**: On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to the causa(s) and mannar stated.

29b. Signatura and titla of certifiar:

29c. Licansa number: 033123

29d. Data signad *(Month, Day, Year)*: 5-25-97

30. Nama and addrass of parson who completad causa of daath (Itam 23a) (Type, Print): Dr. Jonathan Lowenthal M.D., Prince Frederick, MD. 20678

State Registrar

31. Data filad *(Month, Day, Year)*: MAY 28 1997

32. Registrar's Signatura: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

97-2794-510
B.K.S
BERNARD
GRAGER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17276

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BERNARD GARY GRAGER
2. Date of Death (Month, Day, Year): MAY 20, 1997
3. Time of Death: 0745 AM
4a. Facility Name (If not institution, give street and number): 2700 WEST PATAPSCO AVENUE ROOM#8
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

Funeral Director

5. Social Security Number: 205-30-5891
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 57 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 03-01-1940
9. Birthplace (State or Foreign Country): PENNSYLVANIA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 2700 W. PATAPSCO AVENUE
10f. Zip Code: 21227-0584
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TRUCK DRIVER
16b. Kind of Business/Industry: TRUCKING

17. Father's Name (First, Middle, Last): WILLIAM A. GRAGER, SR.
18. Mother's Name (First, Middle, Maiden Surname): WYNONA TAYLOR

19a. Informant's Name/Relationship (Type, Print): CONNIE S. CRAWFORD
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3186 CARDINAL DRIVE, WESTMINSTER, MD. 21157

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): MEADOWRIDGE MEMORIAL PARK — Data: 5/24/97
20c. Location - City or Town, State: ELKRIDGE, MD.

21. Signature of Funeral Service Licensee: Joseph W. Mullen D.
22. Name and Address of Facility: SINGLETON FUNERAL HOME 1 SECOND AVENUE, S.W., GLEN BURNIE, MARYLAND 21061

Physician /Medical Examiner

23a. Part1. Enter tha disaasa, or compiications that caused the daath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ona cause on each line. — Approximate Interval Between Onsat and Death

Immediate Cause (Final disaase or condition resulting in death): a. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated avants resulting in death) Last

b.

Due to (or as a consequence of):

c.

Dua to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably [X] Unknown

24a. Was an autopsy performed? INSPECTION 1 [ ] Yes [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Homa [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: [X] Neturei 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. Laron Locke
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): MAY 20, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Yeer): MAY 28 1997
32. Registrar's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "neturel', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

97 17277

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Neva Virginia Getzandanner			2. DATE OF DEATH (Month, Day, Year): May 14 1997	3. TIME OF DEATH: 3:10PM M
4. SOCIAL SECURITY NUMBER: 212-74-1541	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 95 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Apr. 18, 1902	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): College View Nursing Center		9b. CITY, TOWN OR LOCATION OF DEATH: Frederick		9c. COUNTY OF DEATH: Frederick
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Libertytown		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 11930 Main St.		10f. ZIP CODE: 21762		10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): homemaker		16b. KIND OF BUSINESS/INDUSTRY: own home	
17. FATHER'S NAME (First, Middle, Last): James Shelton			18. MOTHER'S NAME (First, Middle, Maiden Surname): Minnie Burrier	
19a. INFORMANT'S NAME (Type/Print): Beulah Getzandanner/ daughter		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 321 Willow Ave. Frederick, MD 21702		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Chapel Cemetery	DATE: 5/17	20c. LOCATION — City or Town, State: nr. Libertytown, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Catharine O. Hartzler		22. NAME AND ADDRESS OF FACILITY: Hartzler Funeral Home Libertytown, MD		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Hypertensive Cardiovascular Disease	10 years
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer's disease

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Allen J. Gilson MD	D26516	▶ MAY 14 1997

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Allen J. Gilson MD 1475 TANEY AVE FRED MD 21702

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
MAY 16 1997	Julia Strickler Randall

DHMH-16 Rev 1/89

97 17278

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOSEPH JOHN THOMAS GOFF, JR.
2. DATE OF DEATH: MONTH 5 DAY - YEAR 14 - 97
3. TIME OF DEATH: 9:15 A. M
4. SOCIAL SECURITY NUMBER: 243-24-4391
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 80 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): 8 - 3 - 16
8. BIRTHPLACE (State or Foreign Country): North Carolina
9a. FACILITY NAME (If not institution, give street and number): 418 S. Church Street
9b. CITY, TOWN OR LOCATION OF DEATH: Snow Hill
9c. COUNTY OF DEATH: Worcester

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Worcester
10c. CITY, TOWN OR LOCATION: Snow Hill
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 418 S. Church
10f. ZIP CODE: 21863
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6 College (1-4 or 5 +):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): contractor
16b. KIND OF BUSINESS/INDUSTRY: self employed builder
17. FATHER'S NAME (First, Middle, Last): Joseph John Thomas Goff, Sr.
18. MOTHER'S NAME (First, Middle, Maiden Surname): Fannie E. Watson (Goff)
19a. INFORMANT'S NAME (Type/Print): Thomas Britton Goff
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 153, Snow Hill, Md. 21863
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Trobate Scott Cemetery DATE 5/18
20c. LOCATION — City or Town, State: Fremont, North Carolina
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Patricia L. Dennis
22. NAME AND ADDRESS OF FACILITY: Dennis Funeral Home, P.O. Box 87 Snow Hill, Md. 21863

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Myocardial Infarction	Months
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Coronary Artery Disease	Years
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Mitral Regurgitation
Sick Sinus Syndrome

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Joseph Cinderella
29c. LICENSE NUMBER: D44069
29d. DATE SIGNED (Month, Day, Year): ▶ 5-15-97
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Joseph Cinderella, M.D., 106 Milford St. Snow Hill, MD 21863
31. DATE FILED (Month, Day, Year): MAY 16 1997
32. REGISTRAR'S SIGNATURE: Julia Faucher Randall

10

DHMH-16 Rev 1/89

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17279

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Louis Erwin Grimes

2. Date of Death Month: May Day: 08 Year: 1997

3. Time of Death: 1:08 p.m.

4a. Facility Name *(If not institution, give street and number)*: Deer's Head Center

4b. City, Town, or Location of Death: Salisbury

4c. County of Death: Wicomico

Funeral Director

5. Social Security Number: 218-34-9014

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 59 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

6. Date of Birth *(Month, Day, Year)*: Sept.23,1937

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residance of Decedant

10a. State: Md.

10b. County: Queen Anne's

10c. City, Town or Location: Stevensville

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 106 Love Point Road

10f. Zip Code: 21666

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Navar Married 2☐Married 3☐Widowed 4☒Divorcad XX

12. Was Decedent Evar in U.S. Armed Forcas? 1☐Yas 2☐No XX If Yas, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐Yas 2☒No XX Specify:

14. Race - American Indian, Black, Whita, atc. Specify: White

15. Decedent's Education *(Specify only highast grada compiatad)*: Elamentary/Secondary (0-12): 6 / Collega (1-4or 5+):

16a. Dacadant's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratirad)*: Waterman/Carpenter

16b. Kind of Businass/Industry: Self Employed

17. Fathar's Nama *(First, Middla, Last)*: Charles E. Grimes

18. Mothar's Nama *(First, Middla, Maidan Surnama)*: Buelah Stallings

19a. Informant's Name/Ralationship *(Type, Print)*: (Sister) Mrs. Dorothy Collins

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 106 Love Point Rd., Stevensville, Md. 21666

20a. Mathod of Disposition: 1☒Burial 2☐Cramation 3☐Ramoval from Stata 4☐Donation 5☐Othar *(Spacify)*

20b. Placa of Disposition *(Nama of cematary, crematory or othar placa)*: Stevensville Cemetery

Data: May 12,1997

20c. Location - City or Town, Stata: Stevensville, Md.

21. Signature of Funeral Service Licensee: ▶ Chad M. Hofenbein

22. Nama and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 106 Shamrock Rd., Chester, Md. 21619

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only one causa on aach lina.

Approximata Intarval Batwaan Onsat and Daath

Immadiata Causa (Final disaasa or condition rasulting in daath)

a. End stage renal disease — 3 years

Dua to (or as a consaquanca of):

Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or Injury that initiatad avants rasulting in daath) Last

b. Sepsis — 4 days

Dua to (or as a consaquanca of):

c. Diabetes mellitus — years

Dua to (or as a consaquanca of):

d.

Part II. **Othar significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yas 2☒No

24b. Wara autopsy findings availabla prior to completion of causa of death? 1☐Yas 2☐No

25. Was casa rafarrad to medical examinar? 1☐Yas 2☒No

26. Placa of Death *(Check only one)*: Hospital: 1☒Inpatiant 2☐ER/Outpatient 3☐DOA Othar: 4☐Nursing Homa 5☐Rasidance 6☐Othar *(Spacify)*

27. Mannar of Death: 1☒Natural 2☐Accidant 3☐Suicida 4☐Homicida 5☐Panding invastigation 6☐Could not be datarmined

28a. Data of Injury *(Month, Day Yaar)*

28b. Tima of Injury

28c. Injury at Work? 1☐Yas 2☐No

28d. Dascribe how injury occurrad

28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. *(Spacify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1☒**Cartifying Physician**: To tha bast of my knowladga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2☐**Medical Examinar**: On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to the causa(s) and mannar stated.

29b. Signatura and titla of cartifiar: ▶ Hwang, M.D.

29c. Licansa number: D16003

29d. Data signad *(Month, Day, Yaar)*: 5/8/97

30. Nama and addrass of parson who completad causa of daath (Item 23a) (Type, Print): Inja J. Hwang, M.D., P.O.Box 2018, Salisbury, MD 21802-2018

State Registrar

31. Data filad *(Month, Day, Yaar)*: MAY 12 1997

32. Registrar's Signatura: ▶ Gina Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pagas 1 and 2 should be filad within 72 hours aftar daath with tha Maryland Dapartmant of Haalth and Mantal Hygiana.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: Tha law requiras that the daath certificata be axacutad within 24 hours aftar daath.

To the Funeral Director: Aftar this certificata has been signad by tha attanding physician and completaly filled in by tha funaral director, paga 2 should be datachad for usa as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17280

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Maurice Edward Giles ~~Giles~~
2. Date of Death (Month, Day, Year): May 22 1997
3. Time of Death: 2:38P
4a. Facility Name *(If not institution, give street and number)*: The Memorial Hospital
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 216-07-7846
6. Sex: ☒ M ☐ F
7. Age *(In yrs. last birthday)*: 81 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June 30, 1915
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: Queen Anne's
10c. City, Town or Location: Grasonville
10d. Inside City Limits: ☐ Yes ☒ No
10a. Street and Number: 118 Marshy Creek Road
10f. Zip Code: 21638
10g. Citizen of What Country?: U.S.A.

11. Marital Status: ☐ 1 Never Married ☒ 2 Married ☐ 3 Widowed ☐ 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? ☒ 1 Yes ☐ 2 No — If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): ☐ 1 Yes ☒ 2 No — Specify:
14. Race - American Indian, Black, White, etc. — Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Heavy Equip.Oper & Mechanic
16b. Kind of Business/Industry: Construction

17. Father's Name *(First, Middle, Last)*: Charles Giles
18. Mother's Name *(First, Middle, Maiden Surname)*: Winnie Bush

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Bertha Giles (Wife)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 118 Marshy Creek Rd., Grasonville, Md. 21638

20a. Method of Disposition: ☒ 1 Burial ☐ 2 Cremation ☐ 3 Removal from State ☐ 4 Donation ☐ 5 Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Md. Veterans Cemetery — Date: May 27, 1997
20c. Location - City or Town, State: Crownsville, Md.

21. Signature of Funeral Service Licensee: Thomas K. Fellenbein
22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 106 Shamrock Rd., Chester, Md. 21619

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	Prolonged hypotension	6 days
Due to (or as a consequence of): b.	Septicemia	7 days
Due to (or as a consequence of): c.	Urinary tract infection	7-8 days
Due to (or as a consequence of): d.		

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Acute Renal failure, pneumonia, Deep venous thrombosis left leg, recent hip fracture - open reduction

23b. Did tobacco use contribute to the cause of death? ☐ 1 Yes ☒ 2 No ☐ 3 Probably ☐ 4 Unknown

24a. Was an autopsy performed? ☐ 1 Yes ☒ 2 No
24b. Were autopsy findings available prior to completion of cause of death? ☐ 1 Yes ☐ 2 No

25. Was case referred to medical examiner? ☐ 1 Yes ☒ 2 No
26. Place of Death *(Check only one)*: Hospital: ☒ 1 Inpatient ☐ 2 ER/Outpatient ☐ 3 DOA — Other: ☐ 4 Nursing Home ☐ 5 Residence ☐ 6 Other *(Specify)*

27. Manner of Death: ☒ 1 Natural ☐ 2 Accident ☐ 3 Suicide ☐ 4 Homicide ☐ 5 Pending investigation ☐ 6 Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? ☐ 1 Yes ☐ 2 No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: ☒ 1 **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ 2 **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Laurence D. Bolan MD
29c. License number: D 27409
29d. Date signed *(Month, Day, Year)*: 5-23-97
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 27 1997
32. Registrar's Signature: June Davidson-Gunnels

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17281

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CATHERINE R. GREENWOOD

2. Date of Death Month Day Year: May 16, 1997

3. Time of Death: 11:12 P.M.

4a. Facility Name *(If not institution, give street and number)*: PRINCE GEORGES HOSPITAL CENTER

4b. City, Town, or Location of Death: Cheverly

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 578-66-9410

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 93 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 9, 1903

9. Birthplace *(State or Foreign Country)*: Washington, D. C.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Temple Hills

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3515 Orme Drive

10f. Zip Code: 20748

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decadent's Education *(Specify only highest grede completed)*: Elemantery/Secondary (0-12): 8; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT usa retired)*: Housewife

16b. Kind of Business/Industry: Private

17. Father's Neme *(First, Middle, Last)*: Unknown

18. Mother's Name *(First, Middle, Meiden Surnema)*: Helen Flemings

19a. Informent's Name/Relationship *(Type, Print)*: Helen Greenwood Allen - Daughter

19b. Malting Addrass *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 3515 Orme Drive, Temple Hills, Maryland 20748

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Placa of Disposition *(Neme of cemetery, cremetory or other piece)*: Maryland National Memorial Park

Date: 5/22/97

20c. Location - City or Town, State: Laurel, Md

21. Signature of Funeral Service Licansee: John T. Stewart III

22. Name and Address of Fecility: STEWART FUNERAL HOME, Inc. 4001 Benning Road, N.E., Washington, D. C.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in daath)

e. Atherosclerotic Heart Disease — 5/16/97

Dua to (or as a consequanca of):

Sequentiatly list conditions, if eny, laading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in daath) Lest

b. Cardiac arrythmia — years.

Due to (or es a consequenca of):

c.

Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Right Leg gangrene

23b. Did tobacco uee contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to complation of cause of daath? 1☐ Yes 2☐ No

25. Was casa referred to medical examiner? 1☐ Yes 2☒ No

28. Piece of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Homa 5☐ Residence 6☐ Othar *(Specify)*

27. Manner of Deeth: 1☒ Neturat 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending Invastigation 6☐ Could not be determinad

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, streat, fectory, office building, etc. *(Specify)*

28f. Location *(Straet end Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Phyeician:** To the best of my knowladge, deeth occurred et the time, dete end place, and due to the cause(s) and mannar as stated. 2☐ **Medical Examiner:** On the besis of examination end/or investigation, in my opinion, death occurred at the time, dete and placa, end due to the cause(s) and manner steted.

29b. Signature and title of certifier: Rakesh Arora, M.D.

29c. License number: D20108

29d. Date signed *(Month, Dey, Year)*: 5/17/97

30. Nama and eddress of person who completed cause of daath (Item 23a) (Type, Print): Rakesh Arora, M.D., 14300 Gallant Fox Lane, Suite 222, Bowie, MD 20715

State Registrar

31. Date filed *(Month, Day, Yeer)*: MAY 21 1997

32. Registrar's Signature: John Brucker Purdell

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17282

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: James Carroll Gass
2. Data of Death Month Day Yaar: May 9, 1997
3. Time of Death: 7:05 PM
4a. Facility Name *(If not institution, give street and number)*: 38320 Point Breeze Road
4b. City, Town, or Location of Death: Coltons Point
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 220-16-4345
6. Sex: 1☒M 2☐F
7. Age *(In yrs. last birthday)*: 71 Yrs.
If Under 1 Yaar: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb 17, 1926
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residance of Decedant

10a. Sfete: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Coltons Point
10d. Insida City Limits: 1☐Yas 2☒No

10e. Street and Number: 38320 Point Breeze Road, P.O. Box 131
10f. Zip Coda: 20626
10g. Citizen of What Country?: U.S.A.

11. Maritel Status: 1☐Never Merried 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedenf Ever in U.S. Armed Forcas? 1☒Yes 2☐No If Yes, Giva Yaar or Datas:
13. Was Decedanf of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.): 1☐Yas 2☒No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedenf's Education *(Specify only highest grade completed)*: Elemantary/Secondary (0-12): 12th Grade; College (1-4or 5+):
16a. Decedant's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Engineer
16b. Kind of Businasa/Industry: Telephone Company

17. Fether's Neme *(First, Middle, Last)*: Joseph Carroll Gass
18. Mothar's Nama *(First, Middle, Meiden Surneme)*: Ella Cullins

19a. Informent's Name/Ralationship *(Type, Print)*: Anne E. Gass/Spouse
19b. Melling Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: P.O. Box 131, Coltons Point, MD 20626

20a. Mathod of Disposition: 1☒Burial 2☐Cramation 3☐Removal from Stata 4☐Donation 5☐Othar *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Sacred Heart Cemetery
Date: 5/12/97
20c. Location - City or Town, Stata: Bushwood, MD 20618

21. Signeture of Funaral Service Licensee: Michael K. Gardiner
22. Nama and Address of Facility: Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Part1. Enter tha disaasa, or complications that causad tha daath. Do not entar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart failure. List *only one* causa on aach lina.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in daath)
a. CONGESTIVE HEART FAILURE — 3 Mo

Dua to (or as a consequence of):
b. METASTATIC MALIGNANT MELANOMA — 6 year

Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disaase or Injury that initiated events resulting in death) Last

Dua to (or as a consequance of):
c.

Dua to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yas 2☒No

24b. Wara autopsy findings available prior to completion of cause of death? 1☐Yas 2☑No

25. Wes casa referred to medical examinar? 1☐Yas 2☒No

26. Place of Daath *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Othar: 4☐Nursing Home 5☒Residance 8☐Other *(Specify)*

27. Mennar of Death: 1☒Natural 2☐Accident 3☐Suicida 4☐Homicide 5☐Pending Investigation 6☐Could not be determined

28a. Data of Injury *(Month, Day Year)*: N/A
28b. Time of Injury: N/A M
28c. Injury at Work? 1☐Yas 2☑No
28d. Describe how injury occurred: N/A
28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: N/A
28f. Location *(Street end Number or Rural Route Number, City or Town, State)*: N/A

29a. Certifiar *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at tha tima, deta and place, and dua to tha cause(s) and mannar as stated. 2☐ **Medical Examiner:** On fhe basis of examinetion and/or Investigation, in my opinion, death occurred at the tima, date and place, and due to tha cause(s) end mannar stated.

29b. Signatura and title of certifier: Robert W. Timmons
29c. Licansa number: D47825
29d. Data signed *(Month, Day, Year)*: 12 MAY 97

30. Nama and address of person who completed causa of daath (Item 23a) (Type, Print): Robert W. Timmons, M.D. Califronia, MD 20619

State Registrar

31. Date filed *(Month, Dey, Yaar)*: MAY 13 1997
32. Registrer's Signatura: Julie Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

13

Amed # 7 Wash. Co. L.B may 29, 1997

97 17283

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
(IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Diane Kay Gordon
2. DATE OF DEATH (Month, Day, Year): May 16, 1997
3. TIME OF DEATH: 18:09 PM
4. SOCIAL SECURITY NUMBER: 218 62 8269
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 43 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Dec 16 1953 (53 ~~97~~)
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Washington County Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Hagerstown
9c. COUNTY OF DEATH: Washington

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Washington
10c. CITY, TOWN OR LOCATION: Hagerstown
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 713 West Washington St.
10f. ZIP CODE: 21740
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: Domestic
17. FATHER'S NAME (First, Middle, Last): Robert Norman Jones
18. MOTHER'S NAME (First, Middle, Maiden Surname): Ethel Mae Ware Jones
19a. INFORMANT'S NAME (Type/Print): Carl L. Gordon
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 713 WWashington St. Hagerstown, MD. 21740
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Rose Hill Cemetery — DATE: 5/22/97
20c. LOCATION — City or Town, State: Hagerstown, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Thomas E. Watts
22. NAME AND ADDRESS OF FACILITY: Watsons Funeral Hm. 24 WBethel St. Hagerstown, MD. 21740

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Full Cardio-pulmonary Arrest	Minutes
DUE TO (OR AS A CONSEQUENCE OF): b.		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.		
DUE TO (OR AS A CONSEQUENCE OF): d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) end manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Martin W. Gallagher Jr MD
29c. LICENSE NUMBER: D 31880
29d. DATE SIGNED (Month, Day, Year): ▶ 5/28/97
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MARTIN W. GALLAGHER, JR MD 11110 Medical Campus Rd. Hagerstown
31. DATE FILED (Month, Day, Year): MAY 29 1997
32. REGISTRAR'S SIGNATURE: Julia Hudson Parker

DHMH-16 Rev 1/89

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17284

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
SHIRLEY	MAE	GRAY	May 18, 1997	8:40 a.m.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
11047 Powell Rd.	Thurmont,	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-46-5431	1☐M 2☒F	50 Yrs.			Jan. 10, 1947	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Frederick	Thurmont	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
11047 Powell Rd.	21788	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10		Laundry worker	Nursing Institution

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Albert Glen Smith	Pauline Evelyn Boyer

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
James N. Gray, / son	11047 Powell Rd./ Thurmont, Maryland 21788

20a. Method of Disposition	20b. Place of Disposition (Name of cemetary, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Resthaven Memorial Gard.	5-21-97	Frederick, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Raymond Peterson	Stauffer Funeral Home 1621 Opossumtown Pike/ Frederick, Md. 21702

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cardiopulmary Arrest	
Due to (or as a consequence of):	b. Pancreatic CA	3 mo
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
M.D.	D47651	5-19-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph Asuncion, M.D. / 1564 Opossumtown Pike, Frederick, Maryland 21702

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 20 1997	Julie Strickler-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 17285

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ARTHUR ALLEN GOBLE

2. Date of Death Month / Day / Year: MAY 13 1997

3. Time of Death: 0640

4a. Facility Name *(If not institution, give street and number)*: SACRED HEART HOSPITAL

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 225-12-2564

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: OCT. 29, 1923

9. Birthplace *(State or Foreign Country)*: NEW YORK

Usual Residence of Decedent

10a. State: WV

10b. County: HAMPSHIRE

10c. City, Town or Location: CAPON BRIDGE

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: HC 83, BOX 52

10f. Zip Code: 26711

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1943-1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: BRICKLAYER

16b. Kind of Business/Industry: CONSTRUCTION

17. Father's Name *(First, Middle, Last)*: RUSSELL GOBLE

18. Mother's Name *(First, Middle, Maiden Surname)*: MARION MAJOR

19a. Informant's Name/Relationship *(Type, Print)*: RUTH GOBLE

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: HC 83, BOX 52, CAPON BRIDGE, WV 26711

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: OMPS CREMATION SERVICE | Date: 5/16/97

20c. Location - City or Town, State: WINCHESTER, VIRGINIA

21. Signature of Funeral Service Licensee: Jerry B. Giffin

22. Name and Address of Facility: GIFFIN FUNERAL HOME, INC. P. O. BOX 100, CAPON BRIDGE, WV 26711

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Heart Stroke (Exact cause not known) — unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Due to (or as a consequence of): HTN X D — unknown
c. Due to (or as a consequence of): Emphysema — unknown
d. Due to (or as a consequence of): ASCVD — unknown

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)* | 28b. Time of Injury | 28c. Injury at Work? 1 [ ] Yes 2 [ ] No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D07164

29d. Date signed *(Month, Day, Year)*: MAY 14 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jack D Harvey 425 Seton Drive Cumberland MD 21502

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 20 1997

32. Registrar's Signature: John Davison Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1 see

6/3/97

Georgie:

Subject: Arthur Allen Goble (DOD: 5/13/97)

This certificate was accepted when I was out of the office. Please note the cause of death. It states "Heart Stopped (Exact Cause Not Known). Because this is not a local funeral director, I decided to send this on to you to handle. Sorry!

Nancy Simpson

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17286

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert Harry Gilpin
2. Date of Death: Month 5 Day 21 Year 97
3. Time of Death: 0150
4a. Facility Name (If not institution, give street and number): Memorial Hospital & Med. Center
4b. City, Town, or Location of Death: CUMBERLAND MD
4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 212-12-0697
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 78 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 21, 1919
9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Allegany
10c. City, Town or Location: cumberland
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 12110 Bedford Road, N.E.
10f. Zip Code: 21502
10g. Citizen of What Country? USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): university Professor
16b. Kind of Business/Industry: Education
17. Father's Name (First, Middle, Last): James B. Gilpin
18. Mother's Name (First, Middle, Maiden Surname): Helen Askey
19a. Informant's Name/Relationship (Type, Print): Donna Ferguson/Per. Rep.
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21502: 13115 Ferguson Lane, N.E. cumberland, Md.
20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Smithsburg crematory
Date: May 22, 1997
20c. Location - City or Town, State: Smithsburg, Maryland
21. Signature of Funeral Service Licensee: Ernest A. Riley, Jr.
22. Name and Address of Facility: Leasure-Stein, INC, 230 Baltimore Ave. cumberland, Md, 21502

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Malignant lymphoma — Due to (or as a consequence of): — 4yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. — Due to (or as a consequence of):
c. — Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how Injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D17565
29d. Date signed (Month, Day, Year): May 21, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. ANTHONY J. BOLLINO, JR. 955 FREDERICK STREET CUMBERLAND, MARYLAND

State Registrar

31. Date filed (Month, Day, Year): MAY 23 1997
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

GILPIN ROBERT H
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

20
MKS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17287

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARIANNA GROSS

2. Date of Death Month: May Day: 23 Year: 97

3. Time of Death: 10:57 a.m.

4a. Facility Name *(If not institution, give street and number)*: LIONS MANOR NURSING HOME

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 214-52-2111

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 87 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: FEB 9 1910

9. Birthplace *(State or Foreign Country)*: PA.

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ALLEGANY

10c. City, Town or Location: CUMBERLAND

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: RFD#3 BEDFORD ROAD

10f. Zip Code: 21502

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOUSE KEEPER

16b. Kind of Business/Industry: HOUSE KEEPER

17. Father's Name *(First, Middle, Last)*: CHARLES WALTER FRANTZ

18. Mother's Name *(First, Middle, Maiden Surname)*: NELLYE BROTEMARKLE

19a. Informant's Name/Relationship *(Type, Print)*: MARGARET A. HARR DAUGHTER

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 517 LIMESTONE ROAD CARLISLE, PA. 17013-4348

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: PLEASANT GROVE CEMETERY

Date: MAY 28 1997

20c. Location - City or Town, State: CUMBERLAND MD. RFD#3

21. Signature of Funeral Service Licensee: ▶ Jennifer Merritt

22. Name and Address of Facility: MERRITT-ADAMS FUNERAL HOME 404 Decatur Street, Cumberland, Maryland 21502

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pulmonary edema — 1 day

Due to (or as a consequence of):

b. Congestive Heart failure — 1 wk.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Coronary artery disease — 5 years

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Senile dementia, emaciation, s/p. M.I.

s/p. Fx. R & L. hip.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ V. A. Ranjithan

29c. License number: D19750

29d. Date signed *(Month, Day, Year)*: May, 23, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): V.A. Ranjithan, M.D., Lions Manor N.H., Seton Dr. Ext., Cumberland, MD 21502

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 23 1997

Registrar's Signature: ▶

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17288

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Robert C. Heckman

2. Date of Death — Month: May; Day: 17; Year: 1997

3. Time of Death: 4:30 pm

4a. Facility Name *(If not institution, give street and number)*: 4410 Hallet Street

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-26-0641

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 71 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct. 21, 1925

9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 4410 Hallet Street

10f. Zip Code: 20853

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: 1943-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12); College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Accountant

16b. Kind of Business/Industry: Federal Government

17. Father's Name *(First, Middle, Last)*: Robert J. Heckman

18. Mother's Name *(First, Middle, Maiden Surname)*: Edith M. Brady

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Beverly A. Heckman

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4410 Hallet Street, Rockville, MD 20853

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cemetery

Date: 5/21/97

20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: Martha Pickal

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. gastrointestinal bleed. — 1 week

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. metastatic non small cell lung cancer — 6 weeks

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: George A. Sotos MD

29c. License number: D43083

29d. Data signed *(Month, Day, Year)*: MAY 19, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 9707 Medical Center Drive #300 Rockville MD 20850

State Registrar

31. Data filed *(Month, Day, Year)*: MAY 20 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

8+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17289

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Marcia A. Herndon
2. Date of Death: Month: May Day: 19, Year: 1997
3. Time of Death: 5:30 AM
4a. Facility Name (If not institution, give street and number): 3008 Gumwood Drive
4b. City, Town, or Location of Death: Hyattsville
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 246-64-4871
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 55 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 1, 1941
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: MD
10b. County: Prince George's
10c. City, Town or Location: Hyattsville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3008 Gumwood Drive
10f. Zip Code: 20783
10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decadent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: American Indian

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12); College (1-4or 5+): 5+
18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Professor of Ethnomusicology
16b. Kind of Business/Industry: Education

17. Father's Name (First, Middle, Last): George Herndon
18. Mother's Name (First, Middle, Maiden Sumeme): Alma Simmons

19a. Informant's Name/Relationship (Type, Print): Billye G. Talmadge
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 3008 Gumwood Drive, Hyattsville, MD 20783

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Piace of Disposition (Neme of cemetery, crematory or other place): Metropolitan Crematory
Dete: 5/19/97
20c. Location - City or Town, Stete: Alexandria, VA

21. Signature of Funeral Service Licensee: William L Byrd
22. Name end Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastic Breast Cancer — 4 Years

Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest

b. Due to (or es a consequence of):

c. Due to (or as a consequenca of):

d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobecco uee contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residenca 6☐ Other (Specify)

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, end due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete end place, end due to the cause(s) and menner stated.

29b. Signature end title of certifier: Peter Lyon
29c. License number: D37777
29d. Date signed (Month, Dey, Year): 5/19/97

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): 2 ICWELL NORTH DR COLUMBIA MD 21045

State Registrar

31. Date filed (Month, Day, Year): MAY 21 1997
32. Registrar's Signature: Janice Henderson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires thet the death certificete be executed within 24 hours after death.
To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, pege 2 should be detached for use es the burial-transit permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17290

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Lucy E. Hopkins

2. Date of Death Month Day Year: May 22, 1997

3. Time of Death: 7:30 Am

4a. Facility Name *(If not institution, give street and number)*: Wilson Health Care Center

4b. City, Town, or Location of Death: Gaithersburg

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 220-44-1267

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 99 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sept. 26, 1897

9. Birthplace *(State or Foreign Country)*: North Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Gaithersburg

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 211 Russell Avenue

10f. Zip Code: 20877

10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Teacher

16b. Kind of Business/Industry: Elementary Education

17. Father's Name *(First, Middle, Last)*: John B. Hopkins

18. Mother's Name *(First, Middle, Maiden Surname)*: Celia Isabel Greene

19a. Informant's Name/Relationship *(Type, Print)*: Terri H. Rohr

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 811 Brighton Knolls Drive, Brinklow, MD 20862

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Chesapeake Crematory

Date: 5-23-97

20c. Location - City or Town, State: Beltsville, Maryland

21. Signature of Funeral Service Licensee: Ellen W. Rapp

22. Name and Address of Facility: Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. If pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure — 3years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Arteriosclerotic Heart Disease — —

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Azotemia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: James R. Moore MD

29c. License number: 07231

29d. Date signed *(Month, Day, Year)*: May 22, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James R. Moore Jr. 207 Brookes Ave Gaithersburg MD 20877

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 23 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17291

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: THOMAS GALVIN HORGAN

2. Date of Death Month: MAY Day: 17 Year: 1997

3. Time of Death: 1140am

4a. Facility Name *(If not institution, give street and number)*: NNMC 8901 Wisconsin Avenue

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 569-84-5435

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 47 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: NOV 29 1949

9. Birthplace *(State or Foreign Country)*: TEXAS

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: TEXAS

10b. County: KERR

10c. City, Town or Location: KERRVILLE

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 105 TIMBERWAY

10f. Zip Code: 78028

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): | College (1-4or 5+): 5+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: PILOT

16b. Kind of Business/Industry: ARMED FORCES

17. Father's Name *(First, Middle, Last)*: MAURICE CHAPMAN HORGAN

18. Mother's Name *(First, Middle, Maiden Surname)*: JEAN BERMAN

19a. Informant's Name/Relationship *(Type, Print)*: BONNIE HORGAN/ WIFE

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8710 MACHINE SHOP RD., MASCOUTAH, ILL. 62258

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: CHAMBERS CREMATORY | Date: 5/18

20c. Location - City or Town, State: RIVERDALE, MD.

21. Signature of Funeral Service Licensee: W. W. Chambers MD0091

22. Name and Address of Facility: CHAMBERS FUNERAL HOMES,P.A., RIVERDALE,MD.20737

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. METASTATIC MALIGNANT MELANOMA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: None

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)* | 28b. Time of Injury M | 28c. Injury at Work? 1 [ ] Yes 2 [ ] No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD LT. MC, USNR

29c. License number: 155-48-5926/2105

29d. Date signed *(Month, Day, Year)*: 17 May 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): George E. Gentchos 8901 Wisconsin Ave Bethesda, MD 20889

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 19 1997

32. Registrar's Signature: Julia Davidson-Randall

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17292

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Martin M. Holt

2. Date of Death: Month May, Day 14, Year 1997

3. Time of Death: 11:45 am

4a. Facility Name (If not institution, give street and number): Montgomery General Hospital

4b. City, Town, or Location of Death: Olney

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-26-7551

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 71 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 15, 1926

9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 3926 Wendy Lane

10f. Zip Code: 20906

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No. If Yes, Give Year or Dates: Unknown

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Engineer

16b. Kind of Business/Industry: Government

17. Father's Name (First, Middle, Last): Raymond S. Holt

18. Mother's Name (First, Middle, Maiden Surname): Elizabeth M.Martin

19a. Informant's Name/Relationship (Type, Print): Dorothy S. Holt

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3926 Wendy Lane Silver Spring, MD 20906

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery

Date: 5/19/97

20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: Eric S. Scarbo

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Acute Cardio Respiratory Failure — acute

Due to (or as a consequence of):
b. MI, Congestive Heart Failure & COPD. — 6 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. Coronary Artery Disease Recent MI — 1 year

Due to (or as a consequence of):
d. And Recent CABG Needing Post op. Ventilation. — 8 weeks

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

PEG feeding, Peripheral Vascular Disease, Hypertension, Cardiac Arrhythmia, Esophageal Dysphasia, Nutritional Deficiency

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Owen J Lawless MD

29c. License number: D25410

29d. Date signed (Month, Day, Year): May 16 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. O J LAWLESS 3801 INTERNATIONAL Drive SILVER SPRING. MD. 20906

State Registrar

31. Date filed (Month, Day, Year): MAY 19 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Holt, Martin

10+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 17293

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Toshio Hoshide
2. Date of Death (Month, Day, Year): May 18 1997
3. Time of Death: 1047 AM
4a. Facility Name (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 532-05-8077
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 88 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): September 10, 1908
9. Birthplace (State or Foreign Country): Washington

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1993 Milboro Drive
10f. Zip Code: 20854
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Asian

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cartographer
16b. Kind of Business/Industry: United States Government

17. Father's Name (First, Middle, Last): Sokichi Hoshide
18. Mother's Name (First, Middle, Maiden Surname): Toshiko Arita

19a. Informant's Name/Relationship (Type, Print): Chiyoko Doris Hoshide/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1993 Milboro Drive, Rockville, Maryland 20854

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc. Date: May 29, 1997
20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: Michael S. Hogue M00846
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. MYOCARDIAL INFARCTION	2 HRS
Due to (or as a consequence of):	b. CORONARY ARTERY DISEASE	8 YRS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Thomas H. Sinderson, MD
29c. License number: 19144
29d. Date signed (Month, Day, Year): May 18 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THOMAS G. SINDERSON, MD 6410 ROCKLEDGE DRIVE, #200, BETHESDA, Md 20817

State Registrar

31. Date filed (Month, Day, Year): MAY 23 1997
32. Registrar's Signature: Gina Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17294

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: WILLIAM HENRY HOWARD
2. Data of Death Month: MAY Day: 18 Year: 1997
3. Time of Death: 0045 AM
4a. Facility Name *(If not institution, give street and number)*: Suburban Hospital
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 215-38-2988
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 85 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: Jan. 31, 1912
9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Rasidanca of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Kensington
10d. Inside City Limits: 1 [ ] Yas 2 [X] No
10e. Street and Number: 4901 Cushing Drive
10f. Zip Coda: 20895
10g. Citizan of What Country?: USA

11. Marital Status: 1 [ ] Naver Married 2 [X] Marriad 3 [ ] Widowed 4 [ ] Divorced
12. Was Dacedent Ever in U,S. Armed Forcas? 1 [X] Yas 2 [ ] No If Yas, Giva Year or Dates: WW II
13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 1 [ ] Yas 2 [X] No *Specify:*
14. Race - Amarican Indian, Black, White, atc. *Specify:* White

15. Dacedant's Education *(Specify only highast grada compliated)*: Elamentary/Secondary (0-12): Collaga (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratired)*: Auditor
16b. Kind of Businass/Industry: Federal Government

17. Father's Nama *(First, Middla, Last)*: Joseph Cassin Howard
18. Mothar's Nama *(First, Middla, Maidan Surnama)*: Agnes McGrath

19a. Informant's Name/Ralationship *(Type, Print)*: Elizabeth B. Howard
19b. Mailing Addrass *(Street and Numbar or Rural Route Number, City or Town, Stata, Zip Coda)*: 4901 Cushing Drive, Kensington, MD 20895

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Nama of cematary, cremetory or othar placa)*: Gate of Heaven Cemetery — Date: 5/21/97
20c. Location - City or Town, Stata: Silver Spring, MD

21. Signature of Funaral Sarvica Licensee: ▶ Eric S. Scarbo
22. Nama and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter tha diseasa, or complications that caused the death. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only one causa on aach line.

Approximata Intarval Between Onsat and Death

Immediata Causa (Finel disaasa or condition resulting in daath)
a. Pneumonia
Dua to (or as a consequanca of):
b. aspiration
Sequantially list conditions, if any, leading to immadiata causa. Entar Underlying Ceuse (Disaasa or Injury that initiated avents resulting in daath) Last
Dua to (or as a consequance of):
c. Severe encephalopathy
Due to (or as a consequance of):
d.

Part II. **Other aignificant conditions** contributing to daath but not rasulting in tha undarlying causa givan in Part I.
1- Severe Depression
2- Degenerative joint Disease

23b. Did tobacco use contributa to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [✓] No
24b. Ware autopsy findings availeble prior to completion of causa of daath? 1 [ ] Yes 2 [ ] No

25. Was casa referrad to medical examinar? 1 [ ] Yas 2 [✓] No
26. Placa of Daath *(Check only ona)*: Hospital: 1 [✓] Inpatiant 2 [ ] ER/Outpatiant 3 [ ] DOA — Othar: 4 [ ] Nursing Homa 5 [ ] Rasidance 8 [ ] Othar *(Specify)*

27. Mannar of Death: 1 [✓] Natural 2 [ ] Accidant 3 [ ] Sulcida 4 [ ] Homicida 5 [ ] Pending Investigation 6 [ ] Could not be determinad
28a. Date of Injury *(Month, Day Year)*
28b. Tima of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Dascribe how injury occurred
28a. Place of Injury - At homa, farm, straat, factory, office building, atc. *(Spacify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stata)*

29a. Cartifier *(Check only one)*: 1 [✓] **Cartifying Phyaician:** To tha best of my knowledga, daath occurrad at tha tima, data and placa, and dua to the causa(s) and mannar as stated. 2 [ ] **Madical Examiner:** On tha basis of examination and/or invastigation, in my opinion, daath occurrad at the time, date and place, and due to the ceuse(s) and mannar stated.
29b. Signature and title of certifier: ▶ Faruk Ozer M.D.
29c. Licansa number: D. 16409.
29d. Data signed *(Month, Day, Year)*: 5/19/97.
30. Nama and address of person who completed cause of death (Item 23e) (Type, Print): FARUK OZER M.D. 1125 Rockville Pike Rockville, MD, 20852

State Registrar

31. Date filad *(Month, Day, Year)*: MAY 21 1997
32. Registrar's Signature: [signature]

DHMH 16 Rav 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17295

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LILY HUTNER
2. Date of Death (Month, Day, Year): MAY 16, 1997
3. Time of Death: 6:10 PM
4a. Facility Name (If not institution, give street and number): HEBREW HOME OF GREATER WASHINGTON
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 112-34-6885
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 94 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 15, 1902
9. Birthplace (State or Foreign Country): Russia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 6105 Montrose Rd.
10f. Zip Code: 20852
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Philip Popelowsky
18. Mother's Name (First, Middle, Maiden Surname): Sophie (Unobtainable)

19a. Informant's Name/Relationship (Type, Print): Michael Hutner (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10935 Bucknell Dr., Wheaton, MD. 20902

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Knollwood Cemetery
Date: 5-19-97
20c. Location - City or Town, State: Queens, N.Y.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE - ROCKVILLE, MARYLAND 20852

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Ischemic Cardiomyopathy

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] STAFF PHYSICIAN
29c. License number: D 15084
29d. Date signed (Month, Day, Year): MAY 16, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): D.D. PATEL 6105 Montrose Rd., Rockville, MD.

State Registrar

31. Date filed (Month, Day, Year): MAY 19 1997
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17296

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Vivian R. Hylton

2. Date of Death Month May Day 16, Year 1997

3. Time of Death: 10:00 PM

4a. Facility Name *(If not institution, give street and number)*: 14502 Fiske Dr

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 231-32-6598

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 86 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Aug 3, 1910

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 14502 Fiske Dr

10f. Zip Code: 20906

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No. If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): ; College (1-4or 5+): 3

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Branch Chief

16b. Kind of Business/Industry: H.E.W. US Government

17. Father's Name *(First, Middle, Last)*: D. Price Hylton

18. Mother's Name *(First, Middle, Maiden Sumeme)*: Jessie Harter

19a. Informant's Neme/Relationship *(Type, Print)*: Jane H. Evans

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 316 Westfield Ct, NE, Vienna, VA 22180

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Fort Lincoln Crematory

Date: May 19

20c. Location - City or Town, State: Brentwood, MD

21. Signature of Funeral Servica Licensee: ▶ Alan J. Donnell

22. Name and Address of Facility: Hines-Rinaldi Funeral Home 11800 New Hampshire Ave, Silver Spring, MD 20904

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.

Approximete Intervel Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Ischemic Cardiomyopathy — years

Due to (or as a consequence of):

b. old Myocardial Infarctions

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Last

Due to (or as a consequence of):

c. Cardiac arrhythmias.

Due to (or as a consequence of):

d. Congestive Heart Failure

Part II. **Other aignificant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uae contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was en eutopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA. Other: 4 [ ] Nursing Home 5 [✓] Residence 6 [ ] Other *(Specify)*

27. Manner of Deeth: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [✓] **Certifying Physicien**: To the best of my knowledge, death occurred at the time, dete end place, and due to the ceuse(s) end menner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: ▶ M Rotsztain

29c. License number: A 18612

29d. Date signed *(Month, Dey, Year)*: May. 17, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ALBERTO ROTSZTAIN, M.D. 3305 North Leisure World Blvd Silver Spring Md 20906

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 20 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended #19a, 5/28/97, BMW, Montg. Co.

Certificate of Death

Reg. No. 97 17297

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Claire Halpern
2. Date of Death: Month May, Day 15, Year 1997
3. Time of Death: 3:43 P.M.
4a. Facility Name (If not institution, give street and number): Springhouse Manor Care
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 100 14 0217
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Mar 2 1908
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4925 Battery Lane
10f. Zip Code: 20814
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bookkeeper
16b. Kind of Business/Industry: Stationery Store

17. Father's Name (First, Middle, Last): Joseph Seiler
18. Mother's Name (First, Middle, Maiden Surname): Blooma Kerzner

19a. Informant's Name/Relationship (Type, Print): Elaine ~~Smollen~~ Smolen/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11420 Strand Dr. #412 Rockville, MD 20817

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Beth Israel Cemetery
Date: 5/18/97
20c. Location - City or Town, State: Woodbridge, NJ

21. Signature of Funeral Service Licensee: John H Gentry, Jr
22. Name and Address of Facility: Tyes-Pearson Funeral Homes 2847 Wilson Blvd. Arlington, VA 22201

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line.

Approximate Interval Between Onsat and Death

Immadiata Cause (Final disease or condition resulting in death)
a. Congestive Heart Failure
Due to (or es a consequence of):
b. Coronary Artery Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Emphysema

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: A Sheff MD
29c. License number: D36797
29d. Date signed (Month, Day, Year): May 16, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): A Sheff, MD 10215 Fernwood Rd, Bethesda MD 20817

State Registrar

31. Data filed (Month, Day, Year): MAY 20 1997
32. Registrar's Signature: Julia Davidson-Randall

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17298

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): MARION EUGENE HALES

2. Dete of Deeth: Month MAY Dey 17 Yeer 1997

3. Time of Death: 9:15 A.M.

4a. Feciity Neme (If not institution, give street end number): WICOMICO NURSING HOME

4b. City, Town, or Location of Deeth: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 256-46-4453

6. Sex: 1☒ M 2☐ F

7. Age (in yrs. last birthdey): 64 Yrs.

If Under 1 Yeer: Months Deys

If Under 24 Hrs.: Hours Min.

8. Dete of Birth (Month, Dey, Yeer): October 8, 1932

9. Birthplece (State or Foreign Country): Georgia

Usuel Residence of Decedent

10e. Stete: Maryland

10b. County: Wicomico

10c. City, Town or Location: Mardela Springs

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 25067 Delmar Rd.

10f. Zip Code: 21837

10g. Citizen of What Country? USA

11. Meritel Status: 1☐ Never Merried 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Detes: Navy

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Rece - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 9 College (1-4or 5+): -

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Brick Mason

16b. Kind of Business/Industry: Construction

17. Fether's Neme (First, Middle, Last): Carl Hales

18. Mother's Neme (First, Middle, Meiden Surneme): Pearl Burke

19e. Informent's Neme/Reietionship (Type, Print): Amanda M. Hales/wife

19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 25067 Delmar Rd., Mardela Springs, MD 21837

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Pleca of Disposition (Neme of cemetery, cremetory or other piece): Springhill Memory Gardens

Dete: 5/21/97

20c. Location - City or Town, State: Hebron, MD

21. Signeture of Funerel Service Licensee: David A. Thompson M0105

22. Neme end Address of Facility: Holloway Funeral Home, 501 Snow Hill Rd., Salisbury, MD 21804

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mentel Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Pert1. Enter the diseese, or complicetions thet cause the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one cause on eech line.

Approximete Intervel Between Onset end Deeth

Immediete Cause (Finel disease or condition resulting in deeth): e. Carcinoma of Pancreas c Metastasis — 2½ mos.

Due to (or as e consequenca of):

Sequentielly iist conditions, if eny, leading to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in deeth) Lest

b. Due to (or es e consequence of):

c. Due to (or es e consequenca of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

CVA; Insulin Dependent Diabetes Mellitus; Hypertension; Coronary Artery Disease; Carotid Artery Disease; Reflux Esophagitis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveiieble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Pleca of Deeth (Check only one): Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Pleca of Injury - At home, ferm, street, fectory, office buiiding, etc. (Specify)

28f. Location (Street end Number or Rurei Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowiedge, deeth occurred et the time, dete end piece, end due to the cause(s) and menner es steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end pieca, end due to the cause(s) end menner steted.

29b. Signeture end title of certifier: Gregorio Belloso MD

29c. License number: D 29505

29d. Dete signed (Month, Dey, Yeer): 5-17-97

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): GREGORIO M. BELLOSO, M.D. 5302 CHINABERRY DRIVE, SALISBURY, MD 21801

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Division of Vital Records, P.O. Box 68760,

MARION "GENE" HALES

State Registrar

31. Dete filed (Month, Dey, Yeer): MAY 21 1997

32. Registrar's Signeture: Julia Davidson Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17299

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Wells James Hoisey Sr.

2. Date of Death: Month MAY Day 27 Year 1997

3. Time of Death: 0840

4a. Facility Name *(If not Institution, give street and number)*: PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 218-16-7975

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 75 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 09-19-21

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: Somerset

10c. City, Town or Location: Crisfield

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: P.O. Box 643

10f. Zip Code: 21817

10g. Citizen of What Country?: U.S

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Laborer

16b. Kind of Business/Industry: Vault Co.

17. Father's Name *(First, Middle, Last)*: Samuel Hoisey

18. Mother's Name *(First, Middle, Maiden Surname)*: Laura Hoisey

19a. Informant's Name/Relationship *(Type, Print)*: Clifton W. Hoisey Sr. / Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P.O. Box 241 Crisfield, MD 21817

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Hopewell Cemetery

Date: 5/31/97

20c. Location - City or Town, State: Hopewell, MD

21. Signature of Funeral Service Licensee: Anthony E. Ward

22. Name and Address of Facility: Anthony E. Ward Funeral Home 314 Cove St. Crisfield, MD 21817

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause *on* each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	Dead Bowel	2 days
Due to (or as a consequence of): b.	Bleeding Duodenal Ulcer	2 wks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last. Due to (or as a consequence of): c.	ASCAD	years
Due to (or as a consequence of): d.	MI	5 wks

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA. Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: David C. Kerrigan, MD

29c. License number: D44688

29d. Date signed *(Month, Day, Year)*: May 27, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David C. Kerrigan MD 500 Riverside Dr, Suite A206, Salisbury MD 21801

State Registrar

31. Date filed *(Month, Day, Year)*: JUN - 2 1997

32. Registrar's Signature: John Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Wells T. Hoisey 55 yr 218-16-7975

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17300

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: John Robert Hagenbuch
2. Date of Death Month / Day / Year: May 26, 1997
3. Time of Death: 10:02 PM
4a. Facility Name *(If not institution, give street and number)*: Washington County Hospital
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 579-28-6146
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 87 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb. 4, 1910
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Boonsboro
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 8507 Mapleville Road
10f. Zip Code: 21713-1844
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Auditor
16b. Kind of Business/Industry: U.S. General Accounting Office

17. Father's Name *(First, Middle, Last)*: Percy Hagenbuch
18. Mother's Name *(First, Middle, Maiden Surname)*: Gertrude M. Hill

19a. Informant's Name/Relationship *(Type, Print)*: Mary Ann Lizondo, Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4543 King Edward Court, Annandale, VA 22003

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Bear Creek Cem., — Date: May 30, 1997
20c. Location - City or Town, State: Accident, MD 21520

21. Signature of Funeral Service Licensee: D Lynn Newman
22. Name and Address of Facility: Newman Funeral Homes, P.A., 179 Miller Street P. O. Box 275, Grantsville, Maryland 21536

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pulmonary Edema — 3 days
Due to (or as a consequence of):
b. Congestive Heart Failure — 3 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Coronary Artery Disease — yrs
Due to (or as a consequence of):
d. Arteriosclerotic Cardiovascular Disease — yrs

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D18019
29d. Date signed *(Month, Day, Year)*: May 27, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): 32 Dr. V. Datta 334 Mill St. Hagerstown, MD 21740

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 29 1997
32. Registrar's Signature: Julie Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

John Robert Hagenbuch

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17301

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Lest)*: Harry Wilmer Hummel

2. Deta of Death — Month: MAY; Day: 27; Yeer: 1997

3. Time of Death: 08:45A

4a. Facility Nama *(If not institution, give street and number)*: Sacred Heart Hospital

4b. City, Town, or Location of Deeth: Cumberland

4c. County of Deeth: Allegany

Funeral Director

5. Sociel Security Number: 215-05-7188

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 78 Yrs.

If Under 1 Yaar — Months: ; Deys:

If Under 24 Hrs. — Hours: ; Min.:

8. Date of Birth *(Month, Dey, Year)*: April 5, 1919

9. Birthplece *(State or Foreign Country)*: Maryland

Usuel Residence of Decedent

10a. Stete: Maryland

10b. County: Garrett

10c. City, Town or Location: Grantsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Straet and Number: 493 Lower New Germany Road

10f. Zip Code: 21536

10g. Citizen of Whet Country?: USA

11. Maritel Status: 1☐ Naver Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No — If Yas, Give Yaar or Dates: X

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yas, specify Cuben, Mexican, Puerto Rican, atc.): 1☐ Yes 2☒ No *Specify:* X

14. Rece - Americen Indian, Black, Whita, atc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondery (0-12): 12; College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Farmer/Carpenter

16b. Kind of Business/Industry: Farming & Carpentry

17. Fether's Neme *(First, Middle, Last)*: Henry W. Hummel

18. Mother's Name *(First, Middle, Meiden Surneme)*: Emma Warnick

19a. Informent's Neme/Relationship *(Type, Print)*: Rhoda Ruth Hummel, Wife

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 493 Lower New Germany Road, Grantsville, MD 21536

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Trinity Cemetery, May 30, 1997

20c. Location - City or Town, Stete: Grantsville, MD 21536

21. Signeture of Funeral Service Licensee: D Lynn Newman

22. Neme end Address of Facility: Newman Funeral Homes, P.A., 179 Miller Street P. O. Box 275, Grantsville, MD 21536

Physician /Medical Examiner

23e. Part1. Ente the diseasa, or compiications that causad the death. Do not antar the moda of dying, such as cardiac or respiretory errest, shock, or heart failure. List only on cause on each line.

Approximete Interval Between Onset and Death

Immediete Ceuse (Finel diseese or condition resulting in deeth)

e. Cardiac Arrhythmia. — Sudden

Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in deeth) Lest

b.

Due to (or es e consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying ceuse given in Part I.

Chronic Obstructive Lung disease.
Lung Abscess.
Dementia.

23b. Did tobacco uee contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveileble prior to compiation of causa of deeth? 1☐ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Wes cese referred to medicel exeminer? 1☐ Yes 2☒ No

26. Piece of Deeth *(Check only one)*: Hospitel: 1☐ Inpetient 2☒ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28e. Dete of Injury *(Month, Dey Year)*:

28b. Time of Injury: M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred:

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*:

28f. Location *(Straet end Number or Rural Route Number, City or Town, Stete)*:

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceusa(s) and manner es steted. 2☐ **Medical Examiner:** On the basis of exemination end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and manner stated.

29b. Signature end title of certifier: J-E Beitzel MD

29c. License number: D 34079

29d. Deta signad *(Month, Day, Year)*: MAY 28, 1997

30. Neme and address of person who completed ceuse of deeth (Item 23e) (Type, Print): James E Beitzel MD Grantsville MD 21536.

5

State Registrar

31. Dete filed *(Month, Day, Yeer)*: MAY 29 1997

32. Registrer's Signature: Gabi Davidson-Randall

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pagas 1 and 2 should be filed within 72 hours after death with tha Maryland Department of Health and Mental Hygiena.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: Tha law requiras that tha death certificata be axecuted within 24 hours after death.

To the Funeral Director: Aftar this certificata has been signed by the attanding physician and completely filled in by tha funaral director, paga 2 should be datached for usa as tha burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17302

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Rita Miclat Hourihane

2. Dete of Deeth — Month: May Dey: 19, Yeer: 1997

3. Time of Death: 6:18 pm

4a. Fecility Neme (If not institution, give street end number): Genesis Eldercare

4b. City, Town, or Location of Death: Severna Park

4c. County of Deeth: Anne Arundel

Funeral Director

5. Social Security Number: 261-08-0316

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 84 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Yeer): May 22, 1912

9. Birthplace (Stete or Foreign Country): Philippines

Usuel Residence of Decedent

10a. Stete: MD

10b. County: Anne Arundel

10c. City, Town or Location: Severna Park

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 130 Clarence Avenue

10f. Zip Code: 21146

10g. Citizen of Whet Country?: USA

11. Maritel Stetus: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Rece - American Indien, Bleck, White, etc. Specify: Philippino

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondery (0-12): 6 College (1-4or 5+):

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Home

17. Fether's Neme (First, Middle, Last): Juan Miclat

18. Mother's Name (First, Middle, Meiden Surneme): Francesca Garcia

19a. Informent's Neme/Reletionship (Type, Print): James Hourihane, Jr./son

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 130 Clarence Ave., Severna Park, MD 21146

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Plece of Disposition (Neme of cemetery, cremetory or other plece): Lakemont Cemetery

Date: May 22 1997

20c. Location - City or Town, Stete: Davidsonville, MD

21. Signature of Funerel Service Licensee: Robert S. Barranco

22. Neme end Address of Fecility: Barranco & Sons, P.A. Severna Park Funeral Home, 495 GovRitchie Hwy., Severna Park, MD21146

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immediete Ceuse (Finel diseese or condition resulting in deeth): e. DEMENTIA — 3 YEARS

Due to (or as e consequence of):

Sequentielly list conditions, if eny, leeding to immediete ceuse. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest:

b. Due to (or as a consequence of):

c. Due to (or as e consequence of):

d.

Pert II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probebiy 4☑ Unknown

24a. Wes an eutopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medicel exeminer? 1☐ Yes 2☑ No

26. Plece of Deeth (Check only one): Hospitel: 1☐ inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of injury (Month, Dey Yeer)

28b. Time of injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner**: On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner stated.

29b. Signature end title of certifier: Attendig

29c. License number: D21776

29d. Date signed (Month, Dey, Yeer): MAY 20 1997

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): SURYA P. MUNDRA MD 8109 RITCHIE HWY PASADENA 21122

State Registrar

31. Date filed (Month, Dey, Yeer): MAY 27 1997

32. Registrer's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours efter deeth with the Meryland Department of Health end Mentel Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours efter death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17303

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ruth Connie Hubers

2. Date of Death: Month May Day 24 Year 1997

3. Time of Death: 11:10 am

4a. Facility Name (If not institution, give street and number): 1017 Sundown Road

4b. City, Town, or Location of Death: Ferndale

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 250-36-6157

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 70 Yrs. If Under 1 Yaar: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 12/05/1926

9. Birthplace (State or Foreign Country): South Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Ferndale

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1 Wells Avenue

10f. Zip Code: 21061

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Inspector

16b. Kind of Business/Industry: Westinghouse

17. Father's Name (First, Middle, Last): William Howard

18. Mother's Name (First, Middle, Maiden Surname): Beulah Adams

19a. Informant's Name/Relationship (Type, Print): Rev. Michael W. Hubers (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1017 Sundown Road Ferndale, Md. 21061

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Glen Haven Memorial Park

Date: 5-28 1997

20c. Location - City or Town, State: Glen Burnie, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Singleton Funeral Home, P.A. 1 Second Avenue S.W., Glen Burnie, Maryland 21061

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Cardio - respiratory Arrest. — 20 mins

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Date of Injury (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D.

29c. License number: MD 36900

29d. Date signed (Month, Day, Year): 5/25/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): KRISHAN K. SINGAL, 1307 Crain Hwy, S.E.; GLENBURNIE, MD 21061

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): MAY 28 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17304

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Mary R. Howery

2. Date of Death Month: May Day: 22, Year: 1997

3. Time of Death: 940

4e. Facility Neme *(If not institution, give street end number)*: Union Hospital

4b. City, Town, or Location of Death: Elkton

4c. County of Deeth: Cecil

Funeral Director

5. Social Security Number: 212-01-7502

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Day, Year)*: June 3,1912

9. Birthplace *(State or Foreign Country)*: Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Md.

10b. County: Cecil

10c. City, Town or Location: North East

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 769 Old Philadelphia Road

10f. Zip Code: 21901

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: at home

17. Father's Name *(First, Middle, Last)*: Alvin Russell

18. Mother's Name *(First, Middle, Meiden Surname)*: Smithson

19a. Informant's Name/Relationship *(Type, Print)*: Edmond C. Howery

19b. Malling Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 785 Howery Lane, North East, Md. 21901

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Bay View Cemetery | Date: 5/24/97

20c. Location - City or Town, State: Bay View, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Feciility: Gee Funeral Home 259 E. Main St., Elkton, Md. 21921

from

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failura. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)
e. Chronic Obstructive Pulmonary Disease — Years.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings eveileble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Deeth *(Check only one)*: Hospitel: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier: Saehden-S. MD

29c. License number: D23322

29d. Dete signed *(Month, Day, Year)*: 5/23/97

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): S. S. SAEHDEN MD, 118 North ST, Suite 3B ELKTON MD 21921

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 27 1997

32. Registrar's Signature: Julia Davidson-Randall

To be completed by the funeral director after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

permit. Pages 1 and 2 should be filed within 72 hours

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Howery, Mary

5

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17305

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Edwin Whitaker Hoster

2. Date of Death Month Day Year: May 20 1997

3. Time of Death: 1810

4a. Facility Name *(If not institution, give street and number)*: 498 Biggs Highway

4b. City, Town, or Location of Death: Rising Sun

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 180-07-1759

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Aug 18 1911

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: MD

10b. County: Cecil

10c. City, Town or Location: Rising Sun

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 498 Biggs Highway

10f. Zip Code: 21911

10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Technical Rep

16b. Kind of Business/Industry: Aircraft Mfg.

17. Father's Name *(First, Middle, Last)*: Edwin W. Hoster

18. Mother's Name *(First, Middle, Maiden Surname)*: Lillian Langlett

19a. Informant's Name/Relationship *(Type, Print)*: Sandra Vachek, Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 113A Donzen Dr. BelAir MD 21014

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)* / Date: West Nottingham Cmty May 26 1997

20c. Location - City or Town, State: Colora MD

21. Signature of Funeral Service Licensee: Robert T Foard

22. Name and Address of Facility: R. T. Foard Funeral Home, PA
111 S Queen St. Rising Sun MD 21911

To Be Completed by Funeral Director

PN Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Insulin Dependent Diabetes Mellitus

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hypertension Anemia

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d. Atherosclerotic Disease

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Hi Sim MD

29c. License number: D46412

29d. Date signed *(Month, Day, Year)*: 5/21/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Hi S Sim, MD 281 E Main St. Rising Sun MD 21911

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 22 1997

32. Registrar's Signature: Julia Davidson-Randall

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17306

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): George Thomas Harrison

2. Date of Death (Month, Day, Year): May 10, 1997

3. Time of Death: 11:00 a.m.

4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 214-36-0434

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 57 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept.16, 1939

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street end Number: 773 Wembly Dr./ Apt. G

10f. Zip Code: 21701

10g. Citizen of What Country?: United States

11. Maritel Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 [ ] Yes 2 [ ] No Specify:

14. Rece - Americen Indian, Bleck, White, etc. Specify: White

15. Decedent's Educetion (Specify only highest grede completed)

Elementery/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Custodian

16b. Kind of Business/Industry: County Schools

17. Fether's Neme (First, Middle, Last): Garland Harrison

18. Mother's Name (First, Middle, Maiden Surneme): Ida Virginia Cooper

19a. Informent's Name/Relationship (Type, Print): Creta Harrison/ wife

19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code): 773 Wembly Dr./ Apt. G./ Frederick, Maryland 21701

20e. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Rocky Hill Cemetery

Date: 5-13-97

20c. Location - City or Town, State: Woodsboro, Maryland

21. Signature of Funerel Service Licensee: Raymond Peterson

22. Name end Address of Facility: Stauffer Funeral Home 1621 Opossumtown Pike/ Frederick,Md. 21702

To Be Completed by Funeral Director

permit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death) e. Myocardial infarction

Due to (or as e consequence of):

Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in death) Lest

b.

Due to (or as a consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

Lung cancer

Status epilepticus

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of ceuse of death? 1 [ ] Yes 2 [ ] No

25. Was cese referred to medicat examiner? 1 [ ] Yes 2 [X] No

26. Place of Deeth (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Deeth: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28e. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Phyaician:** To the best of my knowledge, death occurred at the time, date and piece, and due to the ceuse(s) and menner as steted. 2 [ ] **Medical Examiner:** On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, dete and place, and due to the cause(s) and menner stated.

29b. Signeture end title of certifier: M Raphaelson MD

29c. License number: D26660

29d. Date signed (Month, Day, Year): 5/12/97

30. Neme and address of person who completed ceuse of death (Item 23a) (Type, Print): Marc Raphaelson, M.D. /915 Toll House Ave./ Frederick,Md. 21701

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter deeth.

To the Funerai Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Dete filed (Month, Day, Year): MAY 14 1997

32. Registrar's Signature: Julia Davidson Randall

DHMH 16 Rev 6/95

97 17307

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ERIC MICHAEL HARRIS			2. DATE OF DEATH (Month, Day, Year): MAY 15, 1997	3. TIME OF DEATH: 11:19 am M
4. SOCIAL SECURITY NUMBER: ---	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS 1, MIN. 2	7. DATE OF BIRTH (Month, Day, Year): MAY 15, 1997	8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): GREATER BALTIMORE MEDICAL CENTER	9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON		9c. COUNTY OF DEATH: BALTIMORE	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Harford	10c. CITY, TOWN OR LOCATION: Bel Air	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 1403 Cherokee Lane	10f. ZIP CODE: 21015	10g. CITIZEN OF WHAT COUNTRY?: USA	

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): == College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): ---	16b. KIND OF BUSINESS/INDUSTRY: ---	
17. FATHER'S NAME (First, Middle, Last): Steve Robert Harris		18. MOTHER'S NAME (First, Middle, Maiden Surname): Terrie Kay DiMauro	
19a. INFORMANT'S NAME (Type/Print): Steve R. Harris - Father	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1403 Cherokee Lane, Bel Air, MD 21015		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Harford Memorial Grdns. DATE: 5/19/97	20c. LOCATION — City or Town, State: Aldino, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Howard K. McComas	22. NAME AND ADDRESS OF FACILITY: Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. EXTREME PREMATURITY (23 WKS)	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. PREMATURE RUPTURE OF MEMBRANE	24HRS
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [✓]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: M.D	29c. LICENSE NUMBER: D38718	29d. DATE SIGNED (Month, Day, Year): 5-15-97
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Sabah Helou GBMC 6701 North Charles Street, Baltimore, 21204		
31. DATE FILED (Month, Day, Year): MAY 19 1997	32. REGISTRAR'S SIGNATURE:	

DHMH-16 Rev 1/89

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17308

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EMILY MORGAN HARRIS

2. Data of Death Month MAY Day 15, Yaar 1997

3. Tima of Death: 11:19 am

4a. Facility Neme (If not institution, giva street and number): GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death: TOWSON

4c. County of Deeth: BALTIMORE

Funeral Director

5. Social Security Number: -----

6. Sex 1☐ M 2☒ F

7. Aga (In yrs. last birthday) Yrs.

If Undar 1 Year: Months / Days

If Under 24 Hrs.: Hours 1 / Min 38

8. Deta of Birth (Month, Day, Year) MAY 15, 1997

9. Birthplace (State or Foreign Country): Maryland

Usuel Rasidance of Decedant

10a. Stata: Maryland

10b. County: Harford

10c. City, Town or Locetion: Bel Air

10d. Insida City Limits 1☐ Yas 2☒ No

10e. Street end Number: 1403 Cherokee Lane

10f. Zip Code: 21015

10g. Citizan of What Country? USA

11. Marital Status 1☒ Navar Merried 2☐ Marriad 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Giva Yaar or Datas:

13. Was Decedant of Hispenic Origin? (Specify Yas or No- If Yes, specify Cuben, Mexican, Puarto Rican, etc.) 1☐ Yas 2☒ No Specify:

14. Race - Amaricen Indian, Black, Whita, etc. Specify: White

15. Dacedant's Education (Specify only highast grada complated)

Elamantary/Secondary (0-12): ---

Collaga (1-4or 5+):

16a. Decedant's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT usa retirad): ---

16b. Kind of Businass/Industry: ---

17. Father's Nama (First, Middle, Last): Steve Robert Harris

18. Mothar's Nama (First, Middla, Maidan Surnama): Terrie Kay DiMauro

19a. Informant's Name/Ralationship (Typa, Print): Steve R. Harris - Father

19b. Meiling Addrass (Straet and Number or Rural Route Number, City or Town, State, Zip Coda): 1403 Cherokee Lane, Bel Air, MD 21015

20a. Mathod of Disposition 1☒ Burial 2☐ Cramation 3☐ Ramoval from State 4☐ Donation 5☐ Othar (Specify)

20b. Place of Disposition (Nama of cemetary, cramatory or othar placa): Harford Memorial Grdns.

Deta: 5/19/97

20c. Location - City or Town, Stete: Aldino, Maryland

21. Signature of Funeral Service (Licensee): Howard K McComas

22. Nama and Address of Facility: Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009

Physician /Medical Examiner

23a. Part I. Entar tha diseesa, or complications that caused tha daath. Do not entar tha moda of dying, such es cardiac or respiratory errast, shock, or haert failura. List only ona causa on aach lina.

Approximete Interval Batween Onset and Death

Immediete Causa (Final diseesa or condition resulting in death)

a. EXTREME PREMATURITY (23 wks)

Dua to (or as e consequance of):

PREMATURE RUPTURE OF MEMBRANES — 24 hrs

Sequantially list conditions, if any, laading to immadiata cause. Entar Underlying Ceusa (Disaase or injury that initieted avents resulting in death) Lest

b. Dua to (or as a consequance of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying ceusa givan in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy parformed? 1☐ Yas 2☐ No

24b. Wara autopsy findings availabla prior to complation of causa of death? 1☐ Yas 2☐ No

25. Was casa rafarrad to medical examinar? 1☐ Yes 2☐ No

28. Place of Daath (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Rasidence 8☐ Othar (Specify)

27. Mannar of Deeth 1☐ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be determined

28a. Data of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28e. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifiar (Check only one) 1☐ **Certifying Physician:** To tha best of my knowledga, daath occurred at tha tima, date end plece, end dua to tha cause(s) and menner as stated. 2☐ **Medical Examinar:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha causa(s) end mannar stated.

29b. Signature and title of certifiar: MD

29c. Licensa number: D38718

29d. Data signed (Month, Day, Year): 5-15-97

30. Nama and address of parson who completed cause of deeth (Item 23a) (Type, Print): Sabah Hebou GBMC, 6701 North Charles Street, Baltimore MD 21204

State Registrar

31. Date filed (Month, Day, Year): MAY 19 1997

32. Registrar's Signatura:

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

97 17309

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
BETTY	JEAN	HANCOCK	May 12, 1997	12:37 PM

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
212-32-0214	1 ☐ M 2 ☒ F	64 YRS.			2/22/1933	Maryland

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Harford Memorial Hospital	Havre de Grace	Harford

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Harford	Aberdeen	1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
302 Perrywood Court Apt. 320	21001	U.S.A.

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO Specify:	Specify: Caucasian

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
7	--- ---	Housewife	Home

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Allen Edward Gibson	Edna Annabelle Matthews

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mark Jones / Son	1574 W. Jarrettsville Rd. Jarrettsville, Md. 21084

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____	Ayres Chapel Cemetery	5/16 White Hall, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ M. Gladden Kurtz III	Kurtz Funeral Home, P.A. Jarrettsville, Maryland

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Irreversible shock	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. ARDS	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Urosepsis And	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. Acute Myocardial infarction	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature]	D 20715	▶ 5-12-97

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
KARMACHYANDRA S. NAIR MD 601 S. Union Ave. Havre de Grace, Md.

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
MAY 19 1997	[signature]

DHMH-16 Rev 1/89

97-2933-033
B.K.S
ROBERT SAMUEL PIERSON
HAMMETT Items:23a part I,27 per MEO G-749

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 7/23/97 dh

Certificate of Death

97 173 10

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert Samuel Pierson Hammett

2. Date of Death (Month, Day, Year): MAY 29, 1997

3. Time of Death: 0656AM

4a. Facility Name (If not institution, give street and number): 4903 COLONEL ADDISON PLACE

4b. City, Town, or Location of Death: UPPER MARLBORO

4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 212-31-0693

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 8 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 17, 1988

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Upper Marlboro

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 4903 Colonel Addison Place

10f. Zip Code: 20772

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 3rd | College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Student

16b. Kind of Business/Industry: School

17. Father's Name (First, Middle, Last): Stuart R. Hammett

18. Mother's Name (First, Middle, Maiden Surname): LaVonne Pierson

19a. Informant's Name/Relationship (Type, Print): Stuart R. Hammett (Father)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4903 Colonel Addison Place Upper Marlboro MD 20772

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Trinity Episcopal Church Cem | June 2, 1997

20c. Location - City or Town, State: Upper Marlboro, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Lee Funeral Home, Inc. 6633 Old Alexandria Ferry RD Clinton, MD 20735

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. CARDIAC ARRHYTHMIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. DYSPLASIA OF CARDIAC AV NODE ARTERY

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29e. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Stephen S. Radentz, MD

29c. License number: O.C.M.E

29d. Date signed (Month, Day, Year): MAY 29, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JUN 09 1997

32. Registrar's Signature: Julia Davidson-Randall

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 17311

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LIZZIE HARRIS
2. Date of Death: Month MAY Day 23 Year 1997
3. Time of Death: 9:12 PM
4a. Facility Name (If not institution, give street and number): SOUTHERN MARYLAND HOSPITAL
4b. City, Town, or Location of Death: CLINTON
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 423-30-9881
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): August 5, 1908
9. Birthplace (State or Foreign Country): Alabama

Usual Residence of Decedent

10e. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Cheltenham
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 10407 Basel Drive
10f. Zip Code: 20623
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Domestic

17. Father's Name (First, Middle, Last): Unknown
18. Mother's Name (First, Middle, Maiden Surname): Unknown

19a. Informant's Name/Relationship (Type, Print): Boyd Harris Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10407 Basel Drive Cheltenham, Maryland 20623

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Forest Hill Memorial
Date: May 29, 1997
20c. Location - City or Town, State: Clinton, Maryland

21. Signature of Funeral Service Licensee: ▶ Lloyd M Custer
22. Name and Address of Facility: Adams Funeral Home 20605 Aquasco Road, Aquasco 20608 Maryland

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
e. Respiratory failure — 10 min
Due to (or as a consequence of):
b. Sepsis
Due to (or as a consequence of):
c. Intestinal obstruction
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ [signature] MD
29c. License number: D46246
29d. Date signed (Month, Day, Year): 5/27/97 MAY 5, 1997
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ASHRAF MEELU MD WALDORF, MD 20603

State Registrar

31. Date filed (Month, Day, Year): MAY 28 1997
32. Registrar's Signature: ▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

vri - AMENDED NO. 5 QACHD 5/23/97 **Certificate of Death**

Reg. No. 97 17312

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
NANCY MARIE HOXTER	May 17,1997	6:15AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
328 Main Street	Stevensville	Queen Anne's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-16-~~5885~~ 5685	1☐ M 2☒ F	75 Yrs.			Oct.27,1921	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Queen Anne's	Stevensville	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizan of What Country?
328 Main Street	21666	U.S.A.

11. Meritel Status	12. Was Decedant Ever in U.S. Armed Forces?	13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	4	Real Estate Agent	Real Estate

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Earnest Webster Clark	Addy Skinner

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Husband Walter G. Hoxter,Sr.	328 Main St., Stevensville, Md. 21666

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Stevensville Cemetery	May 20,1997	Stevensville, Md.

21. Signature of Funeral Service Licensee: Chad M. Helfenbein

22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 106 Shamrock Road, Chester, Md. 21619

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Sudden cardiac death syndrome	
Due to (or as a consequence of):	b. Atherosclerotic cardiovascular disease	10 yrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Hypertension	
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular disease

23b. **Did tobacco use contribute to the cause of death?** 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 8☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	D 29571	5/20/97

30. Name and address of person who completed cause of death (item 23e) (Type, Print)

Paul B. Berez,MD 1655 Crofton Blvd.; Crofton, Maryland

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): MAY 21 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 17313

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Klaus Heinrich Hain

2. Date of Death Month Day Year: May 18, 1997

3. Time of Death: 8:25PM

4a. Facility Name (If not institution, give street and number): 408 Butler's Landing

4b. City, Town, or Location of Death: Stevensville

4c. County of Death: Queen Anne's

Funeral Director

5. Social Security Number: 577-64-8722

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 19, 1923

9. Birthplace (State or Foreign Country): Germany

Usual Residence of Decedent

10a. State: Md.

10b. County: Queen Anne's

10c. City, Town or Location: Stevensville

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 408 Butler's Landing

10f. Zip Code: 21666

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Physicist

16b. Kind of Business/Industry: Research

17. Father's Name (First, Middle, Last): Anton Hain

18. Mother's Name (First, Middle, Maiden Surname): Gertrud Wolten

19a. Informant's Name/Relationship (Type, Print): Gertrud Hain (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 408 Butler's Landing; Stevensville, Md 21666

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Cremation Center

Date: May 21, 1997

20c. Location - City or Town, State: Stevensville, Md.

21. Signature of Funeral Service Licensee: Chad M. Helfenbein

22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 106 Shamrock Rd., Chester, Md. 21619

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Arrest — 5 min

Due to (or as a consequence of):

b. End Stage Parkinson's Disease — 4 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: James Ruppel

29c. License number: D25499

29d. Date signed (Month, Day, Year): 5/20/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James Ruppel 180 Admiral Cochrane Dr Annapolis, MD

State Registrar

31. Date filed (Month, Day, Year): MAY 21 1997

32. Registrar's Signature: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17314

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Daisy Holmes

2. Date of Death Month / Day / Year: May 20 1997

3. Time of Death: 5:50 pm

4a. Facility Name *(If not institution, give street and number)*: Heartland Healthcare of Adelphi

4b. City, Town, or Location of Death: Hyatt.

4c. County of Death: P.G.

Funeral Director

5. Social Security Number: 224-92-4369

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 106 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Feb 18 1891

9. Birthplace *(State or Foreign Country)*: VIRGINIA

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince Georges'

10c. City, Town or Location: Forestville

10d. Inside City Limits: ☒ Yes 2☐ No

10e. Street and Number: 2605 Ryder Avenue

10f. Zip Code: 20747

10g. Citizen of What Country?: USA

11. Meritel Stetus: 1☐ Never Married 2☐ Merried 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes ☒ No If Yes, Give Year or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - Americen Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): unk. / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Farmer

16b. Kind of Business/Industry: Self-employed

17. Father's Name *(First, Middle, Last)*: Haywood Reed

18. Mother's Name *(First, Middle, Maiden Surname)*: Roxieann Powell

19a. Informant's Name/Relationship *(Type, Print)*: Joan Gilbert/grandaughter

19b. Malling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2605 Ryder Avenue Forestville,Md. 20747

20a. Method of Disposition: ☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other piece)*: Gary Cemetery

Date: 05/25/97

20c. Location - City or Town, State: Skipper,Virginia

21. Signature of Funerel Service Licensee: Shelly Bell

22. Neme end Address of Facility: Robert G. Mason Funeral Home, Inc 1661 Good Hope Road,S.E. Washington,D.C. 20020

Physician /Medical Examiner

23a. Part1. Enter the diseese, or compilcations that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediete Cause (Final disease or condition resulting in death)

a. Cardiac Arrhmia (Atrial Fibrillation) — 40 yrs

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury thet Initiated events resulting in deeth) Last

b. Hypertension — 50 yrs

Due to (or as a consequence of):

c. Diabetes

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Renal Failure, arthritis, dysplasia pleural Pneumonia, UTI sepsis

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes ☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes ☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes ☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: ☒ 4 Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: ☒ 1 Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: ☒ 1 **Certifying Physician**: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, end due to the cause(s) end manner stated.

29b. Signature and title of certifier: Gary W. Jones

29c. License number: D30111

29d. Date signed *(Month, Day, Year)*: May 20, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gary W. Jones MD PO Box 385 Laurel Md 20725-0385

State Registrar

31. Dete filed *(Month, Day, Year)*: MAY 22 1997

32. Registrar's Signature: Julia Henderson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 17315

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: BETTY LOU HOUSER
2. Dete of Deeth — Month: MAY — Dey: 16 — Year: 1997
3. Time of Death: 7:13 PM
4a. Feclity Nama *(If not institution, giva straat and number)*: NATIONAL NAVAL MEDICAL CENTER
4b. City, Town, or Location of Death: BETHESDA
4c. County of Deeth: MONTGOMERY

Funeral Director

5. Social Security Number: 522-26-5143
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 73 Yrs. — If Under 1 Yaar: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Day, Yeer)*: AUGUST 22, 1923
9. Birthplece *(Stete or Foreign Country)*: COLORADO

Usual Residence of Decedent

10e. Stete: VA
10b. County: ARLINGTON
10c. City, Town or Location:
10d. Inside City Limits: 1☐ Yas 2☐ No
10e. Street and Number: 2430 FORT SCOTT DRIVE SOUTH
10f. Zip Code: 22202
10g. Citizan of Whet Country?: U.S.A.

11. Maritel Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U,S. Armed Forces? ☒Yas 2☐ No If Yes, Give Yaar or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yes 2☒ No *Specify:*
14. Race - Amarican Indlen, Black, Whita, atc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondery (0-12): — College (1-4or 5+): 2
16e. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT usa retired)*: HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Neme *(First, Middla, Last)*: REX WORRALL
18. Mother's Neme *(First, Middle, Meiden Surneme)*: LUCILE HANEBORG

19e. Informent's Neme/Relationship *(Type, Print)*: WILLIAM D. HOUSER-(HUSBAND)
19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2430 FORT SCOTT DRIVE SOUTH, ARLINGTON, VA 22202

20e. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donetion 5☐ Othar *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or othar place)*: ARLINGTON NATIONAL
Deta: 5/22/97
20c. Location - City or Town, Stete: ARLINGTON, VIRGINIA

21. Signatura of Funeral Service Licensee: Timothy M. Shea
22. Neme end Address of Facility: DEMAINE FUNERAL HOMES, INC. ALEXANDRIA, VIRGINIA 22314

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that causad tha deeth. Do not antar the mode of dying, such as cardiac or raspiratory arrast, shock, or heert failure. List only one ceuse on eech line. — Approximata Intarvel Between Onset and Deeth

Immediete Ceuse (Finel diseese or condition resulting in death): e. SEPSIS
Due to (or es e consequence of):
Sequantially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in death) Lest: b. METASTATIC CANCER
Due to (or es a consequence of):
c.
Dua to (or as a consequenca of):
d.

Part II. **Other eignificant conditions** contributing to death but not rasulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yee 2☐ No 3☐ Probably 4☐ Unknown

24e. Was an autopsy performed? ☒ Yes 2☐ No
24b. Were eutopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No
26. Piece of Death *(Check only one)*: Hospitel: ☒ 1☐ Inpatiant 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Deeth: ☒ 1☐ Neturel 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined
28e. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: ☒ 1☐ **Certifying Phyeician:** To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the besis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete and pleca, and due to the cause(s) end manner stated.
29b. Signature and title of certifier:
29c. Licensa number: D-45356 (MD)
29d. Date signed *(Month, Day, Year)*: 05-19-97
30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): M.W.MITCHELL, LCDR, MC, USN — NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600

State Registrar

31. Dete filed *(Month, Day, Year)*: MAY 22 1997
32. Registrer's Signature:

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 17316

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: DAVID D. HALL
2. Date of Death Month / Day / Year: May 21 1997
3. Time of Death: 3:25 p.m.
4a. Facility Name *(If not institution, give street and number)*: P. G. HOSPITAL CENTER
4b. City, Town, or Location of Death: Cheverly, MD
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 578-16-1252
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 80 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 11-13-16
9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10a. State: Maryland — 10b. County: Prince George — 10c. City, Town or Location: Capitol Heights, MD — 10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 941 Newington Court — 10f. Zip Code: 20743 — 10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elamantary/Secondery (0-12): 12th — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT usa retired)*: Postal Service

16b. Kind of Business/Industry: Government

17. Father's Name *(First, Middle, Last)*: James Hall

18. Mother's Name *(First, Middle, Maiden Surname)*: Hattie Goldring

19a. Informant's Name/Relationship *(Type, Print)*: Marie M. Farrell (daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 941 Newington Court Capitol Heights, MD 20743

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. Olivet Cemetery — Data: 5/28/97

20c. Location - City or Town, State: Washington, D. C.

21. Signature of Funeral Service Licensee: Edward M. Dudley

22. Name and Address of Facility: DUDLEY FUNERAL HOME, 3200 Rhode Island Avenue, Mt. Rainier, MD 20822

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

CR

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Emphysema — 5 years

Due to (or as a consequence of):
b. Gastro-intestinal hemorrhage, unknown site — 5 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)* — 28b. Time of Injury: M — 28c. Injury at Work? 1 ☐ Yes 2 ☐ No — 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* — 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: H. Thomas Foley H.T. Foley MD — 29c. License number: D05698 — 29d. Date signed *(Month, Day, Year)*: 5-22-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Prince George's Hosp Cen. Cheverly, MD 20785

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

5

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 23 1997 — 32. Registrar's Signature: Gabriel Theodore Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17317

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GEORGE W HARTUNG
2. Dete of Death: Month MAY Dey 11 Year 1997
3. Time of Death: 10:05PM
4a. Facility Name (If not institution, give straet and number): Charlotte Hall Veterans' Home
4b. City, Town, or Location of Deeth: Charlotte Hall
4c. County of Deeth: St. Mary's

Funeral Director

5. Sociel Security Number: 218-03-6993
6. Sax: 1■ M 2☐ F
7. Age (In yrs. lest birthday): 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Yeer): February 9, 1921
9. Birthplece (State or Foreign Country): Maryland

Usual Residence of Decedant

10a. Stete: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Charlotte Hall
10d. Inside City Limits: 1☐ Yes 2■ No
10e. Street end Number: 29449 Charlotte Hall Road
10f. Zip Code: 20622
10g. Citizen of Whet Country?: United States

11. Marital Status: 1☐ Never Married 2■ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U,S. Armed Forces? 1■ Yes 2☐ No If Yes, Give Yeer or Detes: WWII
13. Wes Decedant of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2■ No Spacify:
14. Rece - Amarican Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Service Station Manager
16b. Kind of Businass/Industry: Auto Service Station

17. Father's Name (First, Middle, Last): George Hartung
18. Mother's Neme (First, Middle, Maiden Surneme): Ida Stewart

19a. Informent's Name/Reletionship (Type, Print): Audrey R. Hartung, Wife
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 19732 Drop Forge Lane, Gaithersburg, Maryland 20879

20a. Method of Disposition: 1☐ Burial 2■ Cremetion 3☐ Removal from Steta 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetary, cremetory or other piece): Metropolitan Crematory
Dete: 5-13-97
20c. Location - City or Town, Stata: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Edward N. Brinsfield, Jr., #00052
22. Name end Address of Facility: Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, Maryland 20650-0279

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications thet caused the death. Do not enter tha moda of dying, such es cardiac or respiratory arrest, shock, or heert failure. List only one cause on eech line. Approximata Intervel Between Onset end Death

Immediate Ceuse (Final diseese or condition resulting in deeth): e. END STAGE CHRONIC OBSTRUCTIVE LUNG DISEASE 4 YRS

Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury thet Initieted events resulting in deeth) Last:
b.
Due to (or es e consequence of):
c.
Due to (or as a consequence of):
d.

Pert II. **Other significant conditions** contributing to daath but not rasulting in tha underlying causa givan in Part I.: DIABETES; ALZHEIMER DISEASE

23b. Did tobacco use contributa to the causa of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings availabla prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Piece of Deeth (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Straet end Numbar or Rural Routa Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the besis of examinetion end/or Investigation, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) and manner steted.

29b. Signature and title of certifier: Attending
29c. Licansa number: D-44436
29d. Date signed (Month, Day, Year): May 12 97

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): ASHVINKUMAR J PATEL, MD 603 POST OFFICE RD #207 WALDORF MD 20602

State Registrar

31. Dete filed (Month, Day, Year): MAY 13 1997
32. Registrer's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMMEND #8, 5/15/97, DLB, ST. MARY'S CO

Certificate of Death

Reg. No. 97 17318

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Allison Lewis Herbert
2. Date of Death (Month, Day, Year): May 13, 1997
3. Time of Death: 12:15 PM
4a. Facility Name (If not institution, give street and number): Physicians Memorial Hospital
4b. City, Town, or Location of Death: La Plata
4c. County of Death: Charles

Funeral Director

5. Social Security Number: 213-16-2831
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb 21, ~~1921~~ 1918
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Mechanicsville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 28255 Thompson Corner Road
10f. Zip Code: 20659
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12thGrade | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Lab Technician
16b. Kind of Business/Industry: PEPCO

17. Father's Name (First, Middle, Last): Robert Theodore Herbert
18. Mother's Name (First, Middle, Maiden Surname): Mary Zena Moran

19a. Informant's Name/Relationship (Type, Print): Bertha G. Herbert/Spouse
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 28255 Thompson Corner Rd., Mechanicsville, MD 20659

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Charles Memorial Gardens
Date: 5/15/97
20c. Location - City or Town, State: Leonardtown, MD 20650

21. Signature of Funeral Service Licensee: ▶ Mary B. Bizzo
22. Name and Address of Facility: Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Cerebrovascular Accident	< 1 Day
Due to (or as a consequence of):	b. Multi Organ Failure Syndrome	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Congestive Heart Failure, Renal Failure, Myocardial Infarction, Diabetes Mellitus Bradyarrhythmia, Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No
25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Song Chon
29c. License number: D-37174
29d. Date signed (Month, Day, Year): 5/13/97
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Song Chon, MD., Cenna Medical Center, 7C Post Office Road, Waldorf, Maryland 20602

State Registrar

31. Date filed (Month, Day, Year): MAY 14 1997
32. Registrar's Signature: ▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17319

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: LEWIS CALVIN HARRISON
2. Date of Death — Month: MAY Day: 22 Year: 1997
3. Time of Death: 07:15 AM
4a. Facility Name *(If not institution, give street and number)*: Charlotte Hall Veterans Home
4b. City, Town, or Location of Death: Charlotte Hall
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 219-12-3151
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 73 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sep 24, 1923
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Charlotte Hall
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: Rt. 1 Box 474
10f. Zip Code: 20622
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No — If Yes, Give Year or Dates: 1943-1945
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th Grade — College (1-4 or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Gas Pump Operator
16b. Kind of Business/Industry: Gas Station

17. Father's Name *(First, Middle, Last)*: Robert I. Harrison
18. Mother's Name *(First, Middle, Maiden Surname)*: Mary E. Lowery

19a. Informant's Name/Relationship *(Type, Print)*: Doris Buckler
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P.O. Box 81, Mechanicsville, MD 20659

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Christ Episcopal Cemetery — Date: 5/27/97
20c. Location - City or Town, State: Chaptico, MD

21. Signature of Funeral Service Licensee: Michael K. Gardiner
22. Name and Address of Facility: Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Hepatic encephalopathy — 2 weeks

Due to (or as a consequence of):
b. Metastatic Colon Ca — 1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M Sidarous
29c. License number: D45365
29d. Date signed *(Month, Day, Year)*: 5-22-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): MICHAEL Sidarous, 11701 livingston RD #101 Ft Washington MD 20744

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 27 1997
32. Registrar's Signature: Julie Davidson-Randall

DHMH 16 Rev 6/95

4

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17320

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ethel Geneva HOUSE

2. Date of Death: Month: May Day: 27 Year: 1997

3. Time of Death: 2325

4a. Facility Name (If not institution, give street and number): Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 220-26-5161

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 93 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 12, 1903

9. Birthplace (State or Foreign Country): Virginia

Usual Residance of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 851 Guilford Avenue

10f. Zip Code: 21740

10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - Americen Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 6

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Her own home

17. Father's Name (First, Middle, Last): John Snyder

18. Mother's Name (First, Middle, Maiden Surname): Nannie Etta Strickler

19a. Informant's Name/Relationship (Type, Print): June Gelwicks /Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1119 Outer Drive Hagerstown, Maryland 21742

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, cremetory or other piece): Rose Hill Cemetery

Date: May 31, 1997

20c. Location - City or Town, State: Hagerstown, Md.

21. Signature of Funeral Service Licensee: Scott M Nemuth

22. Name and Address of Facility: Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or haart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Systemic Vascular disease — 7 10 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

recent syncope and chest pain of undetermined etiology

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to compilation of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residance 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Samuel Chan

29c. License number: D36655

29d. Date signed (Month, Day, Year): 5/29/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 1185 MT. AETNA RD Hagerstown MD 21740

State Registrar

31. Date filed (Month, Day, Year): MAY 29 1997

32. Registrar's Signature: Julie Strickler Parker

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

House, Ethel Geneva

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17321

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: JULIA ELIZABETH HULL

2. Dete of Death Month: MAY Dey: 23 Yeer: 1997

3. Time of Deeth: 8:45 AM

4a. Fecility Neme *(If not institution, give street end number)*: Williamsport Nursing Home

4b. City, Town, or Locetion of Deeth: Williamsport

4c. County of Deeth: Washington

Funeral Director

5. Sociel Security Number: 212-38-9852

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. lest birthdey)*: 93 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Yeer)*: Sept.1,1903

9. Birthplece *(Stete or Foreign Country)*: MD

Usuel Residence of Decedent

10e. Stete: MD

10b. County: Washington

10c. City, Town or Locetion: Clear Spring,

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 11636 Ashton Road

10f. Zip Code: 21722

10g. Citizen of Whet Country?: U.S.A.

11. Meritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Bleck, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12 years; College (1-4or 5+): 0

16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Teaching

16b. Kind of Business/Industry: Schools

17. Fether's Neme *(First, Middle, Last)*: Adam Brant Kriner

18. Mother's Neme *(First, Middle, Meiden Surneme)*: Melinda Mae Shupp

19e. Informent's Neme/Reletionship *(Type, Print)*: Lillian Kriner

19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 11119 Dam 5 Rd. Clear Spring, MD 21722

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Plece of Disposition *(Neme of cemetery, cremetory or other piece)*: Rose Hill Cem. Date: May 26,1997

20c. Locetion - City or Town, Stete: Clear Spring,MD

21. Signeture of Funerel Service Licensee: ▶ [signature]

22. Neme end Address of Fecility: Thompson Funeral Home, Inc. P.O.Box 310 Clear Spring,MD 21722

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immediete Ceuse (Finel diseese or condition resulting in deeth): e. METASTATIC COLON CANCER — 2 MONTHS

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leeding to immediete ceuse. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest

b. Due to (or es e consequence of):

c. Due to (or es e consequence of):

d.

Pert II. **Other significent conditions** contributing to deeth but not resulting in the underlying ceuse given in Pert I.: MICROCYTIC ANEMIA

23b. Did tobecco use contribute to the ceuse of deeth? 1☐ Yes 2☒ No 3☐ Probebly 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Wes cese referred to medicel exeminer? 1☐ Yes 2☒ No

26. Plece of Deeth *(Check only one)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28e. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*

28f. Locetion *(Street end Number or Rurel Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physicien:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medicel Exeminer:** On the besis of exemineticn and/or investigetion, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: ▶ [signature] STAFF PHYSICIAN

29c. License number: D42046

29d. Dete signed *(Month, Dey, Yeer)*: MAY 23, 1997

30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): GRACE BROOKE, 18100 SLADE SCHOOL ROAD, OLNEY, MD 20832

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: MAY 28 1997

32. Registrer's Signeture: ▶ [signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the deeth certificete be executed within 24 hours after deeth.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17322

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Catharine Hawbaker
2. Date of Death (Month, Day, Year): May 21 1997
3. Time of Death: 1:15 P.M.
4a. Facility Name (If not institution, give street and number): Mennonite Old People's Home
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 169-38-5972
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 19, 1907
9. Birthplace (State or Foreign Country): Penna.

Usual Residence of Decedent

10a. State: MD.
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 13436 Maugansville Rd.
10f. Zip Code: 21740
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Ernest H. Myers
18. Mother's Name (First, Middle, Maiden Surname): Mary Elizabeth Meyers

19a. Informant's Name/Relationship (Type, Print): Louise Wenger
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5954 Long Rd. Greencastle, Pa. 17225

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Meyers Cemetery | Date: 5/24/97
20c. Location - City or Town, State: Mercersburg, Pa.

21. Signature of Funeral Service Licensee: ▶ H. Martin Zimmerman Jr.
22. Name and Address of Facility: Zimmerman And Son Funeral Home Greencastle, Pa. 17225

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Congestive Heart Failure — immediately
Due to (or as a consequence of):
b. Dementia — 15 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Cerumen Impaction

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ W. David Kent
29c. License number: MD-019478-E
29d. Date signed (Month, Day, Year): May 22, 1997
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W. David Kent, MD. 28 R. Fry Street Mercersburg, Pa. 17236

State Registrar

31. Date filed (Month, Day, Year): MAY 23 1997
32. Registrar's Signature: ▶ Julia Bledsoe Bartlett

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17323

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Thomas Hopkins
2. Date of Death Month May Day 10 Year 1997
3. Time of Death: 4 AM
4a. Facility Name (If not institution, give street and number): At home
222 Front Street
4b. City, Town, or Location of Death: Chestertown
4c. County of Death: Kent

Funeral Director

5. Social Security Number: 218-20-9617
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Mar. 18, 1924
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: Kent
10c. City, Town or Location: Chestertown
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street end Number: 222 Front Street
10f. Zip Code: 21620
10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Construction
16b. Kind of Business/Industry: Gregco Contrator

17. Father's Name (First, Middle, Last): Lawrence Hopkins
18. Mother's Name (First, Middle, Maiden Surname): Minnie Sisco

19a. Informant's Name/Relationship (Type, Print): Mrs. Hilda Hopkins Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 222 Front St. Chestertown, Md. 21620

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Aaron Chapel Cem.
Date: 5-17-97
20c. Location - City or Town, State: Rock Hall, Md.

21. Signature of Funeral Service Licensee: [signature] H00510
22. Name and Address of Facility: WALLEY FUNERAL HOME
207 Calvert St. Chestertown, Md. 21620

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	ASCVD	1
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b.	ACUTE MYOCARDIAL INFARCT	INSTANTLY
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Diabetes mellitus

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Harry Paul Ross MD
29c. License number: D10001
29d. Date signed (Month, Day, Year): 5-13-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Deputy med. Examiner
Harry Paul Ross M.D. 516 Washington Ave. Chestertown, Md. 21620

State Registrar

31. Date filed (Month, Day, Year): MAY 14 '97
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17324

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Anna Elizabeth Hynson

2. Date of Death Month: May Day: 13 Year: 1997

3. Time of Death: 2054

4a. Facility Name *(If not institution, give street and number)*: Kent & Queen Anne's Hospital

4b. City, Town, or Location of Death: Chestertown

4c. County of Death: Kent

Funeral Director

5. Social Security Number: 220-12-0611

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 74 Yrs. | If Under 1 Yaar: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: November 30, 1922

9. Birthplece *(Stete or Foreign Country)*: Maryland

Usuel Residence of Decedent

10a. Stete: Maryland

10b. County: Queen Annes

10c. City, Town or Location: Chestertown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 117 Hynson Road

10f. Zip Code: 21620

10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☒ Never Merried 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Give Yaar or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondary (0-12): 11 | College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Domestic

16b. Kind of Business/Industry: Someone else's home

17. Father's Name *(First, Middle, Last)*: Romie Edward Hynson, Sr.

18. Mother's Name *(First, Middle, Maiden Surneme)*: Rosie Mae Kilson

19a. Informent's Name/Reletionship *(Type, Print)*: Jean Jeter/Sister

19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 119 Hynson Road, Chestertown, Maryland 21620

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other place)*: Mt. Pleasant Cemetery/May

Deta: 17, 1997

20c. Location - City or Town, State: Pondtown, Maryland

21. Signature of Funeral Servica Licansee: [signature]

22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620

Physician /Medical Examiner

23a. Pert I. Enter the disease, or complications thet caused the death. Do not entar the mode of dying, such as cerdiac or raspiretory arrest, shock, or heart failure. List only one cause on each line.

Approximata Intervel Between Onset end Death

Immediete Cause (Finel disease or condition resulting in death)

e. Cardiac arrest — 30

Due to (or es e consequence of):

Sequantially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet Initieted events resulting in death) Lest

b. dysrhythmia.

Due to (or es e consequanca of):

c.

Dua to (or as a consequence of):

d.

Part II. **Other elgnificant conditiona** contributing to death but not resulting in the underlying cause given in Part I.: Dementia / DM / Anemia / Hx CVA / ↑ Chol

23b. Did tobacco uaa contribute to the causa of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yas 2☒ No

26. Piece of Deeth *(Check only one)*: Hospitel: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete end plece, and due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) end menner steted.

29b. Signature and title of certifier: [signature]

29c. License number: D0050996

29d. Data signed *(Month, Day, Year)*: 5/15/97

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Neil Stoddard, MD, 100 Brown Street, Chestertown, Maryland 21620

State Registrar

31. Dete filed *(Month, Day, Year)*: MAY 16 '97

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17325

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: TEXIE LEONA HELMICK
2. Date of Death Month Day Year: MAY 16, 1997
3. Time of Death: 1805
4a. Facility Name *(If not institution, give street and number)*: SACRED HEART HOSPITAL
4b. City, Town, or Location of Death: CUMBERLAND
4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 233-62-9712
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 92 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sept. 27, 1904
9. Birthplace *(State or Foreign Country)*: WEST VIRGINIA

Usual Residence of Decedent

10a. State: WV
10b. County: MINERAL
10c. City, Town or Location: KEYSER
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: ROUTE 2, BOX 194-D
10f. Zip Code: 26726
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 8; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER
16b. Kind of Business/Industry: HOME

17. Father's Name *(First, Middle, Last)*: JOHN WILLIAM CROSSLAND
18. Mother's Name *(First, Middle, Maiden Surname)*: LUESSA FLANAGAN

19a. Informant's Name/Relationship *(Type, Print)*: GRACE LEONA WOTRING / DAUGHTER
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: ROUTE 2, BOX 194-D, KEYSER, WV 26726

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: EGLON CEMETERY
Date: 5/19/97
20c. Location - City or Town, State: EGLON, WV

21. Signature of Funeral Service Licensee: Steven M. Upchurch
22. Name and Address of Facility: UPCHURCH FUNERAL HOME, INC. P.O. BOX 1260-FORT ASHBY, WV 26719

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Sepsis — 24 hr.
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Pneumonitis — 24 hr
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: DO 8377
29d. Date signed *(Month, Day, Year)*: MAY 18, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Uriel Yolandia M.D. 924 Seton Drive Cumberland MD 21502

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 20 1997
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17326

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lonnie Schuler Hance
2. Data of Death: Month May 23 1997 Year
3. Time of Death: 135PM
4a. Facility Name (If not institution, give street and number): 4875 Adelina Road
4b. City, Town, or Location of Death: Prince Frederick
4c. County of Death: Calvert

Funeral Director

5. Social Security Number: 279 20 9540
6. Sex: 1☐ M 2☒ F
7. Age (in yrs. last birthday): 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): June 20, 1925
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Calvert
10c. City, Town or Location: Prince Frederick
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4875 Adelina Road
10f. Zip Code: 20678
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): housewife
16b. Kind of Business/Industry: own home

17. Father's Name (First, Middle, Last): Charles Emil Schuler
18. Mother's Name (First, Middle, Maiden Surname): Ida E. Duppenthaler

19a. Informant's Name/Relationship (Type, Print): Young D. Hance- husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4875 Adelina Rd. Prince Frederick Md. 20678

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. Pauls Cemetery | Date: May 28 1997
20c. Location - City or Town, State: Prince FRederick MD

21. Signature of Funeral Service Licensee: B Rausch
22. Name and Address of Facility: Rausch Funeral Home PA 4405 Broomes Is. Rd. Port Republic MD 2067

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. metastatic small cell lung cancer — 18 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D 46314
29d. Date signed (Month, Day, Year): May 24 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul V. Pomilla, M.D. 120 Hospital Rd. Prince Frederick MD 20678

State Registrar

31. Date filed (Month, Day, Year): MAY 28 1997
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 17327

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: RUTH LUCILLE HITE
2. Data of Death Month / Day / Yaar: MAY 16, 1997
3. Time of Death: 7:50pm
4a. Facility Name *(If not Institution, giva street and number)*: SACRED HEART HOSPITAL
4b. City, Town, or Location of Death: CUMBERLAND
4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 220-30-8069
6. Sax: 1☐ M 2☒ F
7. Aga *(In yrs. last birthday)*: 79 Yrs.
If Under 1 Yaar: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Yaar)*: NOV 24 1917
9. Birthplaca *(Stata or Foraign Country)*: MARYLAND

Usual Rasidance of Decadant

10a. Stata: MARYLAND
10b. County: ALLEGANY
10c. City, Town or Location: CUMBERLAND
10d. Inside City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 11315 ORE STREET N.E.
10f. Zip Coda: 21502
10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1☐ Navar Marriad 2☐ Married 3☒ Widowed 4☐ Divorcad
12. Was Decadant Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:
13. Was Decadant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Spacify:*
14. Race - American Indian, Black, Whita, atc. *Specify:* WHITE

15. Decadant's Education *(Specify only highast grada compiatad)*: Elamantary/Secondary (0-12): 12; Collaga (1-4or 5+):
16a. Decadant's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratirad)*: ALLEGANY CO BOARD OF EDUCATION
16b. Kind of Businass/Industry: COOK IN SCHOOLS

17. Fathar's Nama *(First, Middla, Last)*: PRESLEY BROWNING DICKEN
18. Mothar's Nama *(First, Middla, Maidan Surnama)*: LILLIAN HITE

19a. Informant's Nama/Ralationship *(Type, Print)*: WILBUR E. HITE SON
19b. Mailing Addrass *(Strast and Numbar or Rural Routa Numbar, City or Town, Stata, Zip Coda)*: 12216 MASON ROAD N.E. CUMBERLAND MARYLAND 21502

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*
20b. Placa of Disposition *(Nama of camatary, cramatory or othar placa)*: REST LAWN CEMETERY
Data: MAY 19 1997
20c. Location - City or Town, Stata: LAVALE MARYLAND

21. Signatura of Funaral Sarvica Licansaa: Dale L. Merritt
22. Nama and Addrass of Facility: MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina.

		Approximata Intarval Batwaan Onsat and Death
Immadiata Causa (Final disaasa or condition rasulting in daath) a.	Respiratory failure	? hrs days
Dua to (or as a consaquanca of): b.	Adult Resp. distress Syndrome	hrs days
Saquantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or Injury that initiatad avants rasulting in daath) Last: Dua to (or as a consaquanca of): c.	Pulmonary embolism	17 days
d.	Metabolic encephalopathy	3 days

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa givan in Part I.: Distal Common bile duct stricture, suspected Ca S/P Whipple procedure; pancreatic fistula Atrial fibrillation; pneumothorax

23b. Did tobacco use contribute to the cause of death? 1☐ Yas 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Ware autopsy findings available prior to compiation of cause of death? 1☐ Yas 2☐ No

25. Was casa rafarrad to madical axaminar? 1☐ Yas 2☒ No

28. Placa of Daath *(Chack only ona)*: Hospital: 1☒ Inpatiant 2☐ ER/Outpatiant 3☐ DOA; Othar: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding Investigation 6☐ Could not be datarminad

28a. Data of Injury *(Month, Day Yaar)*
28b. Tima of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. *(Specify)*
28f. Location *(Straat and Numbar or Rural Routa Numbar, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowiedga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as statad. 2☐ **Medical Examinar:** On the basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar stated.

29b. Signatura and title of cartifiar: A. B. Flores MD
29c. Licansa number: DO 1532
29d. Data signed *(Month, Day, Yaar)*: MAY 19 1997

30. Nama and addrass of parson who completad causa of daath (Itam 23a) (Type, Print): A. B. FLORES, M.D. 9210 SEDAN DR. CUMBERLAND

State Registrar

31. Data filad *(Month, Day, Yaar)*: MAY 19 1997
32. Registar's Signatura: John Theodore Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17328

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SANDRA SCHEUER HAYWARD

2. Data of Death Month: MAY Day: 15 Year: 1997

3. Time of Death: 0210

4a. Facility Name (If not Institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 218-50-2239

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 43 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): October 3,1953

9. Birthplaca (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Maryland

10b. County: Wicomico

10c. City, Town or Location: Salisbury

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 29783 Jackson Road

10f. Zip Code: 21804

10g. Citizen of What Counfry?: USA

11. Marital Status: 1☐ Navar Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Dacadent Ever in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Yaar or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Raca - Amarican Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondary (0-12): 12

College (1-4or 5+): -

16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary

16b. Kind of Business/Industry: School System

17. Father's Neme (First, Middle, Last): Louis Scheuer II

18. Mother's Neme (First, Middle, Meiden Sumeme): Marjorie Teiser

19e. Informant's Name/Relationship (Type, Print): Gene Lee Hayward / husband

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 29783 Jackson Rd., Salisbury, MD 21804

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Placa of Disposition (Neme of cemetery, crametory or other placa): Beth Israel Cemetery

Date: 5/16/97

20c. Location - City or Town, State: Salisbury, MD

21. Signature of Funeral Service Licensee: David H. Thompson M0105

22. Nama and Address of Facility: Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the daath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one cause on each line.

Approximate Intarval Betwaan Onset and Death

Immediete Cause (Final disease or condition resulting in death)

a. Pulmonary Hemorrhage — immediate

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last

b. Squamous Cell Carcinoma of Lung — 1 year

Due to (or as a consequenca of):

c.

Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yas 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Piaee of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Othar (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or Investigation, In my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: J E Martin, M.D.

29c. Licansa number: 030690

29d. Date signed (Month, Day, Year): May 15, 1997

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): James E. Martin M.D. 145 E. Carroll St., Salisbury, MD

State Registrar

31. Date filed (Month, Day, Year): MAY 16 1997

32. Registrar's Signature: Julia Stevenson Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

SANDRA S. HAYWARD

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17329

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): INFINITY Lynn HOLTON
2. Date of Death (Month, Day, Year): MAY 25 1997
3. Time of Death: 0600
4a. Facility Name (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death:

Funeral Director

5. Social Security Number: 231-73-1424
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 1 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 21, 1995
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Virginia
10b. County: Frederick
10c. City, Town or Location: Winchester
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 104 Williamson Road, Apt. #3
10f. Zip Code: 22602
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 0 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): N/A
16b. Kind of Business/Industry: N/A

17. Father's Name (First, Middle, Last): Robert Jason Holton
18. Mother's Name (First, Middle, Maiden Surname): Renee Marie Snyder

19a. Informant's Name/Relationship (Type, Print): Renee Marie Snyder
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 104 Williamson Rd., Apt. #3, Winchester, VA 22602

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Shenandoah Memorial Park
Date: 5/28/97
20c. Location - City or Town, State: Frederick Co., VA

21. Signature of Funeral Service License: Ernest L Myers
22. Name and Address of Facility: 1600 Amherst St Onpo Funeral Home Winchester, Va 22601

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. HYPERCYANOTIC SPELLS	
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. TETROLOGY OF FALLOT	19 mo
Due to (or as a consequence of):		
	c. FUNGAL SEPSIS	5 days
Due to (or as a consequence of):		
	d. RESPIRATORY FAILURE	7 days

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: PALLISTER-KILLIAN SYNDROME

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings availeble prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete end plece, end due to the ceuse(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: JoAnne Natale MD
29c. License number: RES-000
29d. Date signed (Month, Day, Year): MAY 25, 1997

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print): JOANNE E. NATALE, MD THE JOHNS HOPKINS HOSPITAL

State Registrar

31. Date filed (Month, Day, Year): JUN 09 1997
32. Registrar's Signeture: Lutka Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17330

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: James G. Howard

2. Date of Death Month / Day / Year: May 22 1997

3. Time of Death: 6:05am

4a. Facility Name *(If not institution, give street and number)*: Howard County General Hospital

4b. City, Town, or Location of Death: Columbia

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 002-36-0462

8. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 49 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Aug 6, 1947

9. Birthplace *(State or Foreign Country)*: New Hampshire

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Columbia

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 7623 E Weatherworn Way

10f. Zip Code: 21046

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 5+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Lawyer

16b. Kind of Business/Industry: Self Employed

17. Father's Name *(First, Middle, Last)*: James M. Howard

18. Mother's Name *(First, Middle, Maiden Surname)*: Dorothy Booden

19a. Informant's Name/Relationship *(Type, Print)*: Jan D. Howard/Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7623 E Weatherworn Way Columbia, Maryland 21046

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. View Cemetery

Date: 5-26-97

20c. Location - City or Town, State: Marriottsville, MD

21. Signature of Funeral Service Licensee: ▶ Susan A. Collins - Witzke

22. Name and Address of Facility: Harry H. Witzke Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARDIAC ARREST

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. CARCINOMA METASTASES

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]

29c. License number: D 23081

29d. Date signed *(Month, Day, Year)*: May 22, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr Robert S. Goodwin 9650 Santiago Rd Ste 109 Columbia, MD 21045

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 23 1997

32. Registrar's Signature: ▶ [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

30

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17331

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robinson Carlton Jones, III
2. Date of Death (Month, Day, Year): May 21, 1997
3. Time of Death: 9:50AM
4a. Facility Name (If not institution, give street and number): Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 229-20-8598
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): August 24, 1926
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Wheaton
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 11901 Georgia Avenue
10f. Zip Code: 20902
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorcad
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1945-1948
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Hearing Examiner
16b. Kind of Business/Industry: United States Government

17. Father's Name (First, Middle, Last): Robinson Carlton Jones, Jr.
18. Mother's Name (First, Middle, Maiden Surname): Mabel Louise Davis

19a. Informant's Name/Relationship (Type, Print): Ann J. Comley / sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 125 Winterberry Drive, Athens, Georgia 30606

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc. | Date: May 23, 1997
20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: Barbara J. McMullen Lawrence M00831
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home / Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. Sepsis
Due to (or as a consequence of):
b. Pneumonia
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Cellulitis
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Cardiomyopathy, Peripheral Vascular disease, Coronary Artery Disease, Partial Colectomy, Hypertension

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [✓] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No
26. Place of Death (Check only one): Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residenca 6 [ ] Other (Specify)
27. Manner of Death: 1 [✓] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Dr Michael J Furlong
29c. License number: D39838
29d. Date signed (Month, Day, Year): May 21, 1997
30. Name and address of person who completed cause of death (Item 23a) (Type/Print): Michael J. Furlong, M.D. 10810 Connecticut Avenue, Kensington, MD 20895

State Registrar

31. Date filed (Month, Day, Year): MAY 23 1997
32. Registrar's Signature: Gina Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17332

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: THORVALD W. JORGENSEN
2. Dete of Deeth Month / Dey / Yeer: 5-15-97
3. Time of Death: 3:28 PM
4e. Feciity Neme *(If not institution, give street end number)*: HOLY CROSS HOSPITAL
4b. City, Town, or Location of Death: SILVER SPRING
4c. County of Deeth: MONTGOMERY

Funeral Director

5. Social Security Number: 120-12-1867
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 85 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Yeer)*: NOV. 22, 1911
9. Birthpiece *(Stete or Foreign Country)*: UTAH

Usual Residence of Decedent

10e. Stete: MD.
10b. County: MONTGOMERY
10c. City, Town or Location: SILVER SPRING
10d. Insida City Limits: 1 [X] Yes 2 [ ] No
10e. Street end Number: 2004 OSBORN DR.
10f. Zip Code: 20910
10g. Citizan of Whet Country?: U.S.A.

11. Maritel Stetus: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Detes:
13. Was Decedant of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Ricen, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - Americen Indien, Black, White, etc. *Specify:* WHITE

15. Decedent's Eddcetion *(Specify only highest grede completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 5+
16e. Decedent's Usual Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: ECONOMIST
16b. Kind of Businass/Industry: FED. GOV'T.

17. Fether's Name *(First, Middle, Last)*: THORVALD JORGENSEN
18. Mother's Name *(First, Middle, Meiden Surname)*: PAULINE WOODYATT

19e. Informent's Name/Reletionship *(Type, Print)*: FLORENCE G. JORGENSEN/WIFE
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: SAME AS ITEM #10

20e. Mathod of Disposition: 1 [ ] Buriel 2 [X] Cremation 3 [ ] Removal from Stete 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: CHAMBERS CREMATORY
Dete: 5/17
20c. Locetion - City or Town, State: RIVERDALE, MD.

21. Signature of Funerel Servlce Licensee: W.W. Chamberlain MO0091
22. Neme end Address of Facility: CHAMBERS FUNERAL HOMES, P.A., SILVER SPRING, MD. 20910

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heert feilura. List only one ceuse on aech lina.

Approximate Intervel Between Onset end Death

Immediata Cause (Final diseese or condition resulting in death): e. Arteriosclerotic heart disease — 2 yrs

Dua to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediete ceusa. Enter Underlying Ceuse (Disease or Injury thet initieted evants resulting in death) Lest:
b.
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other aignificant conditione** contributing to deeth but not resulting in the underlying ceuse given in Part I.: Chronic Asthma

23b. **Did tobecco use contribute to the cause of death?** 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings availeble prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was cese referred to medical exeminer? 1 [X] Yes 2 [ ] No

26. Piece of Deeth *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpetient 3 [X] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Mannar of Deeth: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be datarmined

28e. Dete of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Descnibe how injury occurred
28e. Piece of Injury - At home, farm, streat, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifiar *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) and mannar as stated. 2 [ ] **Medical Examiner**: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceusa(s) end menner stated.

29b. Signature end title of certifier: George N. Sengstack M.D.
29c. License number: D12121
29d. Dete signed *(Month, Dey, Yeer)*: 5-15-97

30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print): GEORGE SENGSTACK M.D. 3929 FERRARA DR., SILVER SPRING, MD. 20906

State Registrar

31. Dete filed *(Month, Day, Yeer)*: MAY 19 1997
32. Registrar's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17333

Penelope JARMAN

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Penelope Jarman

2. Date of Death Month: May Dey: 24 Yeer: 1997

3. Time of Death: 1240 PM

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 218-34-8093

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 62 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Year): June 6, 1934

9. Birthplece (State or Foreign Country): New York

Usuel Residence of Decedent

10a. Stete: MD

10b. County: Wicomico

10c. City, Town or Location: Salisbury

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 423 W. College Ave

10f. Zip Code: 21801

10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 1☐ Yes 2☒ No Specify:

14. Race - Americen Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondery (0-12): / College (1-4or 5+): 4

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Medical Assistant

16b. Kind of Business/Industry: Physician's Office

17. Father's Name (First, Middle, Last): Shelby Hammond Jarman

18. Mother's Name (First, Middle, Meiden Surname): Margaret Dunn Duvall

19a. Informant's Neme/Relationship (Type, Print): Margaret J. Webb - sister

19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 689 N. Park DR. Salisbury, MD 21804

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Cambridge Crematory

Dete: 5-25-97

20c. Location - City or Town, Stete: Cambridge, MD

21. Signature of Funeral Service Licensee: B. Keith Phippin, CFSP

22. Neme end Address of Facility: Bounds Funeral Home 705 E. Main St. Salisbury, MD 21804

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line.

Approximete Interval Between Onset end Deeth

Immediete Ceuse (Finel diseese or condition resulting in death)

a. Acute Respiratory arrest 2nd to — 3 days

Due to (or es a consequence of):

b. chronic Respiratory failure due to chronic — 3 Months

Due to (or as a consequence of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in deeth) Lest

c. alcoholic Polyneuropathy — 15 years

Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

osteoporosis & comprom fracture of Thoracic spine

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Wes cese referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☑ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Locetion (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the ceuse(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete and place, end due to the ceuse(s) end manner stated.

29b. Signature and title of certifier: Joseph Z. Badros

29c. License number: D15192

29d. Date signed (Month, Day, Year): 5/24/97

30. Neme and address of person who completed ceuse of death (Item 23e) (Type, Print): Joseph Z. Badros, M.D. 813 B Eastern Shore Dr. Salisbury, MD 21804

State Registrar

31. Dete filed (Month, Dey, Year): MAY 27 1997

32. Registrer's Signature: Julie Chandler Randall

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17334

Item:16b per F.H. G-748 6/10/97 dh

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mildred E. Jones

2. Data of Deeth — Month: May Day: 14 Yaer: 1997

3. Time of Death: 4:00 pm

4a. Facility Name (If not institution, give street end number): 1142 Skyway Drive

4b. City, Town, or Location of Death: Annapolis

4c. County of Deeth: Anne Arundel

Funeral Director

5. Social Security Number: 212-28-3145

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 92 Yrs.

If Under 1 Yaar — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Data of Birth (Month, Day, Year): June 1, 1904

9. Birthplace (Stete or Foreign Country): Maryland

Usual Residenca of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1098 River Bay Road

10f. Zip Code: 21401

10g. Citizen of What Country?: U.S.A.

11. Marital Stetus: 1☒ Never Married 2☐ Merried 3☐ Widowad 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Giva Yaar or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.): 1☐ Yes 2☒ No Specify:

14. Raca - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grada compleled) — Elementary/Secondery (0-12): College (1-4or 5+): 5+

16a. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired): School Teacher

16b. Kind of Business/Industry: Education - County Baltimore ~~City~~

17. Fether's Name (First, Middle, Last): Charles Milton Jones

18. Mother's Nema (First, Middle, Meiden Surnema): Annie Ruth Sellers

19a. Informent's Neme/Relationship (Type, Print): William Harrison/nephew

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 1097 River Bay Rd., Annapolis, MD 21401

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Ramoval from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or othar piece): Emory Chapel Church Cem. Data May 16 1997

20c. Location - City or Town, Stata: Upperco, MD

21. Signature of Funeral Service Licensee: Jones E Barranco

22. Name and Address of Facility: Barranco & Sons, P.A. Severna Park Funeral Home 495 GovRitchie Hwy., Severna Park, MD 21146

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused tha daath. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximata Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Colon Cancer — Due to (or as a consequence of): — 1 year

Sequentially list conditions, if eny, leading to immediate causa. Enter Underlying Cause (Disease or injury thet initiated events resulting in deeth) Last:

b. Due to (or es a consequence of):

c. Due to (or as a consaquanca of):

d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure
Diabetes Mellitus

23b. Did tobacco use contribute to the causa of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an eutopsy performad? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yas 2☐ No

25. Was case referred to medical examiner? 1☐ Yas 2☒ No

28. Plece of Deeth (Check only one) — Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Rasidence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not ba determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, straet, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) and menner es stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) and menner stated.

29b. Signetura and title of certifiar: Michael Atherton MD

29c. License number: D17847

29d. Date signed (Month, Dey, Yaar): 5/15/97

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print): Michael Atherton, MD, 586 Bellrive Dr, #2B, Annapolis, MD 21401

State Registrar

31. Dete filed (Month, Dey, Yaar): 5/15/97 MAY 27 1997

32. Registrar's Signature: Julia Davidson-Randall

To the Hospital or Attending Physician: The law requires thet the death certificete be executed within 24 hours efter death.

To the Funeral Director: After this certificete has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 end 2 should be filed within 72 hours after death with the Merylend Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17335

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Gomalie Jones

2. Date of Death Month / Day / Year: May 12 1997

3. Time of Death: 4:15 p.m.

4a. Facility Name *(If not institution, give street and number)*: STELLA MARIS

4b. City, Town, or Location of Death: TOWSON

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 214-05-2394

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: MARCH 30 1909

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residance of Decedant

10a. State: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: ANNAPOLIS

10d. Insida City Limits: 1 [X] Yas 2 [ ] No

10e. Street and Number: 9 SILVERWOOD CIRCLE APT. 8

10f. Zip Coda: 21403

10g. Citizen of What Country?: US

11. Marital Status: 1 [ ] Nevar Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1 [ ] Yas 2 [X] No If Yas, Giva Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1 [ ] Yas 2 [X] No *Specify:*

14. Race - Amarican Indlan, Black, Whita, atc. *Specify:* BLACK

15. Decedant's Education *(Specify only highast grada complatad)*: Elementary/Secondary (0-12): 9th | Collaga (1-4or 5+): 0

16a. Decedant's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratirad)*: SALESMAN

16b. Kind of Businass/Industry: MD. NATIONAL CEMETERY

17. Fathar's Nama *(First, Middla, Last)*: SAMUEL JONES

18. Mothar's Nama *(First, Middla, Maidan Surnama)*: SARAH BUTLER

19a. Informant's Name/Raiationship *(Type, Print)*: GOMALIE A. JONES, JR. (SON)

19b. Mailing Address *(Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 9 SILVERWOOD CIRCLE APT. 8 ANNAPOLIS, MD. 21401

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Othar *(Specify)*

20b. Placa of Disposition *(Nama of cematary, crematory or othar placa)*: HILL CREST CEMETERY | Data: 5/16/97

20c. Location - City or Town, Stata: ANNAPOLIS, MD.

21. Signatura of Funaral Sarvica Licansee: Harry D. Reese

22. Nama and Addrass of Facility: WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List *only ona* causa *on* aach lina.

Approximata Intarval Batwaan Onset and Death

Immediata Causa (Finai disaasa or condition rasulting in death): a. Congestive Heart Failure — 4 yrs.

Dua to (or as a consaquanca of):

Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disaasa or Injury that initiatad avants rasulting in daath) Last:

b.

Dua to (or as a consaquanca of):

c.

Dua to (or as a consaquanca of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No

24b. Ware autopsy findings available prior to completion of causa of daath? 1 [ ] Yas 2 [ ] No

25. Was casa rafarrad to medical examinar? 1 [ ] Yas 2 [X] No

26. Placa of Death *(Check only ona)*: Hospital: 1 [ ] Inpatiant 2 [ ] ER/Outpatiant 3 [ ] DOA | Othar: 4 [X] Nursing Homa 5 [ ] Rasidance 6 [ ] Othar *(Specify)*

27. Mannar of Death: 1 [X] Natural 2 [ ] Accidant 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Panding Invastigation 6 [ ] Could not be datarmined

28a. Data of Injury *(Month, Day Yaar)* | 28b. Tima of Injury | 28c. Injury at Work? 1 [ ] Yas 2 [ ] No | 28d. Dascribe how injury occurrad

28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. *(Spacify)* | 28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1 [X] **Certifying Physician:** To tha bast of my knowiadga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2 [ ] **Medical Examiner:** On the basis of axamination and/or invastigation, in my opinion, daath occurrad at the tima, data and place, and dua to tha causa(s) and mannar stated.

29b. Signatura and titla of cartifiar: Kendall Faulkner

29c. Licansa number: D 25643

29d. Data signed *(Month, Day, Year)*: 5/13/97

30. Nama and addrass of parson who completed causa of daath (Item 23a) (Type, Print): Kendall Faulkner, M.D. 2300 Dulaney Valley Road, Towson, MD 21204

State Registrar

31. Data filed *(Month, Day, Year)*: MAY 16 1997

32. Registrar's Signatura: Julia Davidson Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

97-2983-025
B.K.S
ROBERT ROY JAMES

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items:23a part I,27 per MEO G-748 6/12/97 dh

Certificate of Death

Reg. No. 97 17336

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert Roy James
2. Date of Death (Month, Day, Year): JUNE 1, 1997
3. Time of Death: 1545 PM
4a. Facility Name (If not institution, give street and number): 550 OLD BAYLANE
4b. City, Town, or Location of Death: HAVRE DE GRACE
4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 217-74-1446
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 39 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 09-07-1957
9. Birthplace (State or Foreign Country): MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: Harford
10c. City, Town or Location: Havre de Grace
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 550 Old Bay Lane
10f. Zip Code: 21078
10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Non-profit Fund Raiser
16b. Kind of Business/Industry: Fund Raising Organization

17. Father's Name (First, Middle, Last): William Smith James
18. Mother's Name (First, Middle, Maiden Surname): Margaret Higinbothom

19a. Informant's Name/Relationship (Type, Print): Mrs. Margaret James - Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 301 Commerce St. #1, Havre de Grace, MD 21078

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Grove Pres. Ch. Cem.
Date: 6/5/97
20c. Location - City or Town, State: Aberdeen, MD

21. Signature of Funeral Service Licensee: ▶ William S. Smith II
22. Name and Address of Facility: Mitchell-Smith Funeral Home, P.A. Havre de Grace, MD 21078-3197

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. SEIZURE DISORDER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? [X] Yes 2 [ ] No

26. Place of Death (Check only one) — Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. [X] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Dennis J. Chute MD
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): JUNE 2, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis J. Chute, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JUN 09 1997
32. Registrar's Signature: Lina Hamilton-Mandella

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State of Maryland / Department of Health and Mental Hygiene 97 17337

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: FRANCIS EARL JANIFER

2. Date of Death — Month: MAY Day: 19 Year: 1997

3. Time of Death: 7:30 PM

4a. Facility Name *(If not institution, give street and number)*: Regency Nursing Home & Rehabilitation Center

4b. City, Town, or Location of Death: Forestville

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577-50-2333

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 75 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan. 6, 1922

9. Birthplace *(State or Foreign Country)*: Dist. of Columbia

Usual Residence of Decedent

10a. State: D. C.

10b. County: N/A

10c. City, Town or Location: Washington

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3298 Fort Lincoln Drive, Northeast #219

10f. Zip Code: 20018

10g. Citizen of What Country?: United States of America

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th — College (1-4or 5+):

18a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Truck Driver

16b. Kind of Business/Industry: Federal Government

17. Father's Name *(First, Middle, Last)*: John Henry Janifer

18. Mother's Name *(First, Middle, Maiden Surname)*: Edna Mae Baker

19a. Informant's Name/Relationship *(Type, Print)*: LaVerne Wilkins (Friend)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1214 - 45th St., SE., Washington, D. C. 20019

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Fort Lincoln Cemetery

Date: 5/23/97

20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: Clinton Lay #810

22. Name and Address of Facility: L. W. Plunkett Funeral Home, 2504 - 28th St., NE., Wash., D. C. 20018-1413

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. RESPIRATORY FAILURE	< one day.
Due to (or as a consequence of):	b. Decube Ulcers	> 4 wks
Due to (or as a consequence of):	c. Severe peripheral vascular disease	
Due to (or as a consequence of):	d. multiple strokes	> 6 wks.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes ; A-fib.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D-34525

29d. Date signed *(Month, Day, Year)*: May 22, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. SanKineni Rao, M.D. 4000 Mitchellville Rd, Suite #214, Bowie, Md 20716

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 23 1997

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To be Completed by Funeral Director

Medical Certification: To be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

97-2304-037
wlc

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17338

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: ASHLEY NICHOLE JONES

2. Dete of Deeth Month / Dey / Yeer: April 27, 1997

3. Time of Death: 550p

4e. Feciity Neme *(If not institution, give street end number)*: RTE. 235 @ MONTANA SNACK BAR (PARKING LOT)

4b. City, Town, or Locetion of Deeth: HOLLYWOOD

4c. County of Death: ST. MARYS

Funeral Director

5. Sociel Security Number: 212-33-8575

6. Sex: 1☐ M 2☒F

7. Age *(In yrs. lest birthday)*: 5 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Yeer)*: May 9, 1991

9. Birthplece *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10e. Stete: Maryland

10b. County: St. Mary's

10c. City, Town or Location: Mechanicsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 26740 Three Notch Road

10f. Zip Code: 20659

10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☒ Never Merried 2☐ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Deles:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Eduestion *(Specify only highest grede completed)*: Elementery/Secondery (0-12): Kindergarden; College (1-4or 5+):

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Student

16b. Kind of Business/Industry: Public School

17. Fether's Neme *(First, Middle, Last)*: Richard Brian Jones

18. Mother's Name *(First, Middle, Maiden Surneme)*: Joyce Ann Williams

19e. Informent's Neme/Reletionship *(Type, Print)*: Richard Brian Jones/Father

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 26740 Three NotchRoad, Mechanicsville, MD 20659

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Name of cemetery, cremetory or other piece)*: Charles Memorial Gardens

Dete: 5/2/97

20c. Location - City or Town, Stete: Leonardtown, Maryland

21. Signeture of Funerel Service Licensee: Michael K Gardiner

22. Neme end Address of Feciity: Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650

Physician /Medical Examiner

23e. Pert1. Enter the diseese, or complications thet caused the deeth. Do not antar the mode of dying, such es cerdiec or respiretory errest, shock, or heart feilure. List only one ceuse on aach lina.

Approximete Intarvel Betwean Onset end Deeth

Immediete Ceuse (Final diseese or condition resulting in death): a. Head and Neck Injuries

Due to (or es a consaquance of):

Sequentielly list conditions, if eny, leeding to immediete ceuse. Enter Underlying Ceusa (Diseese or Injury that initieted events resulting in deeth) Lest:

b. Due to (or es e consequence of):

c. Due to (or as e consequence of):

d.

Pert II. **Other significent conditions** contributing to deeth but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☒ Yes 2☐ No

24b. Were eutopsy findings evellable prior to completion of ceuse of deeth? 1☒ Yes 2☐ No

25. Wes case referred to medicel exeminer? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* SCENE

27. Menner of Death: 1☐ Neturel 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending invastigation 6☐ Could not be determinad

28e. Dete of Injury *(Month, Dey Yeer)*: 4-27-97

28b. Time of Injury: 1634p M

28c. Injury et Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: pedestrian struck by car

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*: Street

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*: Rt 235 Hollywood, MD

29a. Certifier *(Check only one)*: 1☐ **Certifying Physicien:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es steted. 2☒ **Medical Examiner:** On tha basis of exeminetion end/or Invastigation, in my opinion, deeth occurred et tha time, date and place, end dua to the causa(s) end mannar stated.

29b. Signeture and title of certifier: Dennis J. Chute, MD

29c. License number: O.C.M.E.

29d. Date signed *(Month, Dey, Yeer)*: April 28, 1997

30. Neme end eddress of persen who compleated causa of death (Item 23e) (Type, Print): Dennis J. Chute, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed *(Month, Day, Yeer)*: MAY 01 1997

32. Registrer's Signetura: Judi Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(3)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended item 19b per F.D. 5/21/97, Carroll Co., wjl 20c 5/23/97

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17339

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edward Burgess Jennings Sr.

2. Date of Death Month Day Year: May 20, 1997

3. Time of Death: 0205

4a. Facility Name (If not institution, give street and number): Carroll County General Hospital

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 213-09-5825

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 24, 1918

9. Birthplace (State or Foreign Country): Maryland

Usual Residance of Decadant

10a. State: MD

10b. County: Carroll

10c. City, Town or Location: Manchester

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2252 Bachmans Valley Road

10f. Zip Code: 21102

10g. Citizan of What Country?: United States

11. Marital Status: 1☐ Naver Married 2☒ Married 3☐ Widowad 4☐ Divorced

12. Was Decedant Ever in U.S. Armed Forcas? 1☒ Yas 2☐ No If Yas, Giva Yaar or Dates: WWII

13. Was Dacadant of Hispanic Origin? (Specify Yas or No- if Yes, specify Cuban, Maxican, Puerto Rican, atc.) 1☐ Yes 2☒ No Specify:

14. Race - Amaricen Indian, Black, White, atc. Specify: White

15. Dacedant's Education (Spacify only highast grade completed)

Elementery/Secondary (0-12): 12

Collaga (1-4or 5+):

16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired): Salesperson

16b. Kind of Businass/Industry: Insurance

17. Fathar's Nama (First, Middle, Last): Albert Jennings

18. Mothar's Name (First, Middle, Maidan Surnema): Ella Metcalf

19a. Informant's Neme/Relationship (Type, Print): Opal Jennings, wife

19b. Mailing Address (Straat and Number or Rural Route Number, City or Town, Stata, Zip Coda): 2252 Bachmans Valley Rd., Manchester, MD ~~21101~~ 21102

20a. Mathod of Disposition: 1☐ Burial 2☐ Cremation 3☐ Ramoval from Stata 4☐ Donation 5☒ Othar (Specify) Entombment

20b. Place of Disposition (Nema of cematary, cramatory or othar place): Holly Hills Mausoleum

Date: 05/23/97

20c. Location - City or Town, Stata: Essex, MD ~~Chapel~~

21. Signature of Funaral Service Licensaa: Katherine Pritts - Surcitor

22. Name and Address of Facility: Pritts Funeral Home & Chapel, 412 Washington Rd., Westminster, MD 21157

Physician /Medical Examiner

23a. Part1. Enter tha disaasa, or complications that ceused the daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach tina.

Approximata Intarval Batwaen Onset and Death

Immediata Cause (Final disaasa or condition resulting in daath)

a. pneumonia — 1 mo

Dua to (or as a consaquanca of):

Sequantially list conditions, if any, leading to immadiata causa. Antar Underlying Causa (Disaasa or injury that initiatad avants resulting in daath) Last

b. COPD — 10 yrs

Dua to (or as a consaquanca of):

c. Smoking — 45 yrs

Dua to (or as a consaquanca of):

d.

Part II. Other significant conditions contributing to daath but not resulting in tha underlying ceusa givan in Part I.: Alzheimers 2° m i D

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of daath? 1☐ Yes 2☐ No

25. Was cesa referred to medical examinar? 1☐ Yes 2☒ No

26. Place of Daath (Check only one): Hospital: 1☒ Inpatiant 2☐ ER/Outpatiant 3☐ DOA; Othar: 4☐ Nursing Home 5☐ Rasidance 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Sulcida 4☐ Homicida 5☐ Panding investigation 6☐ Could not be datarmined

28a. Data of Injury (Month, Day Yaar)

28b. Tima of Injury: N/A

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Dascribe how injury occurred

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

28f. Location (Streat and Number or Rural Route Number, City or Town, Stata)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, daath occurred at the time, date and place, and due to the causa(s) and manner as stated. 2☐ Medical Examiner: On tha basis of examination and/or investigation, in my opinion, daath occurred at tha time, date and place, and due to the ceuse(s) and mannar statad.

29b. Signature and title of certifier: John Middleton

29c. License number: D25443

29d. Data signed (Month, Day, Yaar): 5/20/97

30. Nema and address of person who completed cause of death (Item 23a) (Type, Print): 488 Poole Road Westminster, Md 21157

State Registrar

31. Data filed (Month, Day, Yaar): MAY 21 1997

32. Registrar's Signatura: Julia Hudson Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17340

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Catherine Marie Jameson
2. Dete of Deeth: Month May Dey 24 Year 1997
3. Time of Death: 3:27 p.m.
4a. Facility Neme *(If not institution, give street and number)*: 519 Linden Lane
4b. City, Town, or Location of Death: La Plata
4c. County of Death: Charles

Funeral Director

5. Social Security Number: 577-26-4766
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 75 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Year)*: Dec. 8 1921
9. Birthplece *(State or Foreign Country)*: MD

Usual Residence of Decedent

10e. Stete: MD
10b. County: Charles
10c. City, Town or Location: LaPlata
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 519 Linden Lane
10f. Zip Code: 20646
10g. Citizen of Whet Country?: U.S.A.

11. Merital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Rece - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 11 — College (1-4or 5+):
16e. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Secretary
16b. Kind of Business/Industry: Lutheran Social Services

17. Fether's Neme *(First, Middle, Last)*: Andrew Petersen
18. Mother's Neme *(First, Middle, Meiden Surneme)*: Marie Nielsen Petersen

19e. Informent's Neme/Reletionship *(Type, Print)*: Earl Richardson
19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 11325 Annabelle Dr. Issue, MD 20645

20e. Method of Disposition: 1☒ Buriel 2☐ Cremation 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Nemo of cemetery, crematory or other pleca)*: Shiloh Methodist Cem.
Dete: 5/27/97
20c. Location - City or Town, Stete: 7 Bryans Road, MD

21. Signature of Funerel Service Licensee: David A. Echols M00945
22. Name and Address of Fecility: AREHART-ECHOLS FUNERAL HOME, INC. P.O. Box 567 LaPlata, MD 20646

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complicetions thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximete Interval Between Onset and Death

Immediete Cause (Finel disease or condition resulting in death): e. Lung Cancer with Metastasis — 6 wo.

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last:
b.
Due to (or es e consequence of):
c.
Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28e. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete end place, end due to the ceuse(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, dete end piece, and due to the cause(s) end manner stated.

29b. Signeture end titie of certifier: Krishan M. Mathur
29c. License number: D28352
29d. Date signed *(Month, Dey, Year)*: May 27, 1997

30. Neme end address of person who completed cause of death (Item 23e) (Type, Print): Krishan Mathur, M.D. - P. O. Box 2729, La Plata, MD 20646

State Registrar

31. Dete filed *(Month, Dey, Year)*: MAY 27 1997
32. Registrer's Signeture: Julia Hawkins Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17341

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: SARAH MOORE JONES

2. Date of Death Month Day Year: May 10, 1997

3. Time of Death: 0215

4a. Facility Name *(If not institution, give street and number)*: Peninsula Reg. Medical Center

4b. City, Town, or Location of Death: Salisbury

4c. County of Death: Wicomico

Funeral Director

5. Social Security Number: 219-07-6280

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 92 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 11, 1904

9. Birthplace *(State or Foreign Country)*: Md.

Usual Residence of Decedent

10a. State: Md.

10b. County: Wicomico

10c. City, Town or Location: Quantico

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 23045 Nanticoke Road

10f. Zip Code: 21865

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12): 11

College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Educator

16b. Kind of Business/Industry: Public Schools

17. Father's Name *(First, Middle, Last)*: Albert Moore

18. Mother's Name *(First, Middle, Maiden Surname)*: Danie Dashiell

19a. Informant's Name/Relationship *(Type, Print)*: Thelma J. Martin

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2900 32nd St.,S.E., Washington, D.C.20020

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St James Cemetery

Date: 5/17

20c. Location - City or Town, State: Quantico, Md.

21. Signature of Funeral Service Licensee: MOO-417

22. Name and Address of Facility: Messick Funeral Home, P.O. Box 61 Bivalve, Maryland 21814

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Acute myocardial infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: COPD, Sarcoid

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D20683

29d. Date signed *(Month, Day, Year)*: 5/13/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Stephen H. Laffey MD, 20565 Nanticoke Rd, Nanticoke, MD 21840

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 14 1997

32. Registrar's Signature:

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17342

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOSEPH EDWARD KRISIEWICZ SR. / JOSEPH EDWARD KRISIEWICZ SR.

2. Date of Death: Month 5 Day 4 Year 97

3. Time of Death: 10:10

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 189-01-7697

6. Sex: 1☒M 2☐F

7. Age (In yrs. last birthday): 89 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): October 11, 1907

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Wicomico

10c. City, Town or Location: Salisbury

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 5691 N. Nithsdale Drive

10f. Zip Code: 21801

10g. Citizen of Whet Country?: USA

11. Marifel Status: 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Rece - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): -

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Draftsman

16b. Kind of Business/Industry: Heavy equipment

17. Fether's Name (First, Middle, Last): Stanley Krisiewicz

18. Mother's Name (First, Middle, Meiden Surneme): Stella Lucasevich

19a. Informant's Name/Relationship (Type, Print): Joseph E. Krisiewicz Jr./son

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 5691 N. Nithsdale Dr., Salisbury, MD 21801

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removel from State 4☐Donation 5☐Other (Specify)

20b. Piece of Disposition (Name of cemetery, cremetory or other piece): Salisbury Crematory

Dete: 5/5/97

20c. Location - City or Town, Stete: Salisbury, MD

21. Signature of Funerel Service Licensee: ▶ David H. Thompson MO1051

22. Name end Address of Fecility: Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21804

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. CONGESTIVE HEART FAILURE

Due to (or as e consequence of):

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last

b. A S C V D.

Due to (or as e consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Wes en eutopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)

Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury et Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: Thа law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for usa as the burial-transit

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the besis of exemination end/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) end manner stated.

29b. Signeture and title of certifier: ▶ D J Vradnicki

29c. License number: D20912

29d. Dete signed (Month, Dey, Year): 5/4/97

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): Dennis Chadnicki 403 Quincy St. Salisbury, Md. 21801

State Registrar

31. Dete filed (Month, Day, Year): MAY 07 1997

32. Registrar's Signature: Judy Davidson Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17343

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Charles Ernest Kinsey

2. Date of Death: Month 05 Day 20 Year 1997

3. Time of Death: 0130

4a. Facility Name (If not institution, give street and number): Anne Arundel Medical Center

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 215 05 0371

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 88 Yrs.

If Under 1 Yaar: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 04/09/1909

9. Birthplace (State or Foreign Country): Maryland

Usual Rasidence of Decedant

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 2 Clumber Hill

10f. Zip Code: 21405

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yaar or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, atc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - Americen Indian, Black, White, atc. Specify: White

15. Decedent's Educetion (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bank Executive

16b. Kind of Business/Industry: Finance/Banking

17. Father's Name (First, Middle, Last): Albert Stace Kinsey

18. Mother's Name (First, Middle, Maiden Surname): Lula M. Stagge

19a. Informent's Name/Relationship (Type, Print): Leah Kinsey (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2 Clumber Hill, Annapolis MD 21405

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Piece of Disposition (Name of cemetery, crematory or othar place): Metropolitan Crematory

Date: 5/21

20c. Location - City or Town, State: Alexandria VA

21. Signature of Funeral Servica Licensee: Melanie Wilhelm Stagge

22. Name and Address of Facility: Advent Funeral & Cremation Services, Annapolis MD 21401

Physician /Medical Examiner

23a. Part1. Enter tha disease, or complications that caused tha death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heert failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Pneumonia — 1 week

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Othar significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

Heart Failure
Renal Failure
Strokes

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of ceuse of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Deeth (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigetion 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, straat, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, end due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) and manner steted.

29b. Signature and title of certifier: R. L. Hochman, MD

29c. License number: D05 / 92

29d. Date signed (Monty Day, Year): 5/21/97

30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print): Richard I. Hochman, MD 1833A Forest Dr, Annapolis, Md 21401

State Registrar

31. Date filed (Month, Day, Year): MAY 22 1997

32. Registrar's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health end Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours efter death.
To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

97 17344

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): WALTER KING			2. DATE OF DEATH: MONTH MAY DAY 19 YEAR 1997	3. TIME OF DEATH: 3:30 PM M
4. SOCIAL SECURITY NUMBER: 058-07-3977	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 83 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year): MAY 28, 1913	8. BIRTHPLACE (State or Foreign Country): ILLINOIS
9a. FACILITY NAME (If not institution, give street and number): HEBREW HOME OF GREATER WASHINGTON		9b. CITY, TOWN OR LOCATION OF DEATH: ROCKVILLE		9c. COUNTY OF DEATH: MONTGOMERY

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: MONTGOMERY	10c. CITY, TOWN OR LOCATION: GAITHERSBURG	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 9923 TAMBAY COURT		10f. ZIP CODE: 20879	10g. CITIZEN OF WHAT COUNTRY?: UNITED STATES

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): +1	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): PRODUCER	16b. KIND OF BUSINESS/INDUSTRY: RADIO / TV
17. FATHER'S NAME (First, Middle, Last): ABRAHAM KATZ		18. MOTHER'S NAME (First, Middle, Maiden Surname): HELEN FRANKL	
19a. INFORMANT'S NAME (Type/Print): BETTY KING (WIFE)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9923 TAMBAY COURT - GAITHERSBURG, MARYLAND 20879	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): MT. ARARAT CEMETERY DATE 5/23	20c. LOCATION — City or Town, State: FARMINGDALE, L.I.-NEW YORK
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Frank A. Stone		22. NAME AND ADDRESS OF FACILITY: DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE - ROCKVILLE, MD. 20852	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. MULTI-INFARCT DEMENTIA	2 YEARS
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. —	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. —	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [X]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: M.D. Attending Physician	29c. LICENSE NUMBER: D 18084	29d. DATE SIGNED (Month, Day, Year): ▶ May 19, 1997
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): D.D. PATEL, M.D. 6141 MONTROSE RD, ROCKVILLE, MD 20852		
31. DATE FILED (Month, Day, Year): MAY 22 1997	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17345

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Sadie Fleisher Kramer

2. Date of Death Month Day Year: May 15, 1997

3. Time of Death: 12:04 PM

4a. Facility Name *(If not institution, give street and number)*: Washington Adventist Hospital

4b. City, Town, or Location of Death: Takoma Park

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 196-20-1864

8. Sex: 1☐ M 2☒ F

7. Age *(in yrs. last birthday)*: 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: February 7, 1909

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residance of Decedant

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: University Park

10d. Insida City Limits: 1☒ Yas 2☐ No

10e. Street and Number: 6600 Queens Chapel Road

10f. Zip Coda: 20782

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Navar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*

14. Raca - American Indian, Black, White, atc. *Specify:* White

15. Decedent's Education *(Specify only highast grada completed)*: Elamentary/Secondary (0-12): 12; Collaga (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retirad)*: Statistical Typist

16b. Kind of Business/Industry: Dept. of State

17. Fathar's Nama *(First, Middla, Last)*: Aaron Fleisher

18. Mothar's Nama *(First, Middla, Maidan Surnama)*: Molly Young

19a. Informant's Name/Ralationship *(Type, Print)*: Marcia Posner

19b. Mailing Address *(Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 18105 Hollingsworth Drive, Rockville, MD 20855

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Placa of Disposition *(Nama of cematary, crematory or othar placa)*: Mt. Lebanon Cemetery

Data: 5-18-97

20c. Location - City or Town, Stata: Adelphi, Maryland

21. Signature of Funaral Sarvica Licansaa: ▶ Eileen W. Rapp

22. Nama and Addrass of Facility: Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 20910

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused tha death. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart tailura. List only ona causa on aach lina.

Approximata Intarval Between Onset and Death: one hour

Immediata Causa (Finai disaasa or condition rasulting in death)

a. Acute myocardial infarction

Dua to (or as a consequance of):

b. Hypertension

Sequantially list conditions, if any, laading to immediata cause. Entar Underlying Causa (Disaasa or injury that initiated avants resulting in death) Last

Dua to (or as a consaquence of):

c.

Dua to (or as a consaquence of):

d.

Part ii. **Other significant conditions** contributing to death but not rasulting in the underlying causa given in Part i.: Gout

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings available prior to compilation of causa of death? 1☐ Yas 2☒ No

25. Was casa rafarrad to medical examinar? 1☐ Yas 2☒ No

26. Placa of Death *(Check only one)*: Hospital: 1☐ inpatiant 2☒ ER/Outpatient 3☐ DOA Othar: 4☐ Nursing Homa 5☐ Rasidance 8☐ Othar *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)*: NA

28b. Tima of injury: NA M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Cartifiar *(Check only one)*: 1☒ **Cartifying Physician:** To the best of my knowledga, daath occurrad at tha tima, data and placa, and due to the cause(s) and mannar as statad. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and piece, end due to the cause(s) and mannar stated.

29b. Signature and titla of cartifiar: ▶ Alla Krishnamurthy

29c. Licansa number: D38139

29d. Data signed *(Month, Day, Year)*: 5/16/97

30. Nama and addrass of parson who compilatad causa of death (Item 23a) (Type, Print): SITA KRISHNAMOORTHY MD; 12201, Plum Orchard Drive Silverspring, MD 20904

State Registrar

31. Data filad *(Month, Day, Year)*: MAY 19 1997

32. Registrar's Signature: Jana Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17346

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Albert Richard Kuster

2. Date of Death Month / Day / Year: May 13, 1997

3. Time of Death: 6:40 A.M.

4a. Facility Name *(If not institution, give street and number)*: Montgomery General Hospital

4b. City, Town, or Location of Death: Olney

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 212-68-4136

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 30 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Aug. 25, 1966

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2804 Blue Spruce Lane

10f. Zip Code: 20906

10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Hair Stylist

16b. Kind of Business/Industry: Hair Salon

17. Father's Name *(First, Middle, Last)*: Robert Edward Kuster

18. Mother's Name *(First, Middle, Maiden Surname)*: Lillian Elizabeth Clem

19a. Informant's Name/Relationship *(Type, Print)*: Lillian Elizabeth Kuster/Mother

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2804 Blue Spruce Lane, Silver Spring, MD 20906

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Parklawn Memorial Park | Date: May 16, 1997

20c. Location - City or Town, State: Rockville, Maryland

21. Signature of Funeral Service Licensee: Michael P. Kutta M00348

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 W. Montgomery Avenue, Rockville, Maryland 20850-2805

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Congestive Heart Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Severe Dilated Cardiomyopathy — 1-2 months

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Pneumonia, Respiratory Failure.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)* | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Murarka, M.D.

29c. License number: D29816

29d. Date signed *(Month, Day, Year)*: MAY 13, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RADHEY MURARKA, 50 WEST EDMONSTON DRIVE ROCKVILLE MD.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

20

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 19 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17347

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: LILLIAN MAE KNOTTS

2. Date of Death Month Day Year: MAY 25, 1997

3. Time of Death: 12:15 AM

4a. Facility Name *(If not institution, give street and number)*: CUPPETT & WEEKS NURSING HOME

4b. City, Town, or Location of Death: OAKLAND

4c. County of Death: GARRETT

Funeral Director

5. Social Security Number: 236-76-8326

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: JAN 29, 1919

9. Birthplace *(State or Foreign Country)*: WV

Usual Residance of Decedent

10a. State: WV

10b. County: PRESTON

10c. City, Town or Location: EGLON

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: P.O. BOX 83

10f. Zip Code: 26716

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 11 / College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Father's Name *(First, Middle, Last)*: IRA MONROE HARSH

18. Mother's Name *(First, Middle, Meiden Surneme)*: CORA LORETTA HEWITT

19a. Informant's Name/Relationship *(Type, Print)*: ANITA LANTZ

19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: P.O. BOX 83 EGLON, WV 26716

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or othar place)*: EGLON CEMETERY

Date: 5/27/97

20c. Location - City or Town, State: EGLON, WV

21. Signeture of Funeral Service Licensee: ▶ [signature] M00167

22. Name and Address of Facility: P.O. BOX 243 DURST FUNERAL HOME - OAKLAND, MD 21550

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onsat and Death

Immediate Cause (Final disease or condition resulting in death)

a. BREAST CANCER — 2 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Death *(Check only one)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpatient 3☐ DOA Othar: 4☒ Nursing Home 5☐ Residence 6☐ Othar *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physicien:** To the best of my knowledge, death occurred et the time, dete and place, and due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]

29c. Licansa number: H26154

29d. Data signed *(Month, Day, Year)*: 5/27/97

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): P. DANIEL MILLER, D.O. 2008 MARYLAND HIGHWAY MT. LAKE PARK, MD 21550

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 27 1997

32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Divlsion of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 17348

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: IVA M KENNEDY
2. Date of Death Month: MAY Day: 29 Year: 97
3. Time of Death: 0112
4a. Facility Name *(If not institution, give street and number)*: Anne Arundel Medical Center
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 214-34-3846
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 60 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 23, 1937
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Annapolis
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 130 Hearne Road
10f. Zip Code: 21403
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Caucasian

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Robert W. Witt
18. Mother's Name *(First, Middle, Maiden Surname)*: Zellie F. Cook

19a. Informant's Name/Reletionship *(Type, Print)*: John F. Kennedy, Jr. (son)
19b. Malling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3309 Oak Drive Edgewater, Md. 21037

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mayo Methodist Church Cem. — Date: 5-31-97
20c. Location - City or Town, State: Edgewater, Md.

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, Md. 21041

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac of respiretory arrest, shock, or heert failure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Causa (Final diseese or condition resulting in death)
a. SEPSIS — 12h
Due to (or as a consequence of):
PNEUMONIA — 36h

Saquantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Dua to (or as a consequence of):
d.

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying cause given in Part I.
COPD
DM
Obesity
HASCVD

23b. Did tobacco use contribute to the cause of death? 1☐ Yee 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physicfen:** To the best of my knowledge, death occurred at the time, date end piece, and due to the cause(s) and menner as steted. 2☐ **Medfcal Examfner:** On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]
29c. License number: D21438
29d. Date signed *(Month, Day, Year)*: May 29 97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MICHAEL J. CLARK 1836 CONRADGER AVE STE 120 ANNAPOLIS MD 21401

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 30 1997
32. Registrar's Signature: ▶ Julia Davidson Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17349

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RITA MILDRED KNIGHT
2. Date of Death: Month MAY Day 22, Year 1997
3. Time of Death: 05:00 am
4a. Facility Name (If not institution, give street and number): 307 EVA AVE
4b. City, Town, or Location of Death: LINTHICUM
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 219-12-4008
8. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 71 Yrs.
If Under 1 Yaar: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAY 24, 1925
9. Birthplace (State or Foreign Country): DELAWARE

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: LINTHICUM
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 307 EVA AVE.
10f. Zip Code: 21090
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puerto Rican, atc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, atc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 YEARS; College (1-4or 5+): NONE
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SECRETARY
16b. Kind of Business/Industry: C.S.X. RAILROAD

17. Fathar's Nama (First, Middle, Last): LEROY SHERMAN
18. Mothar's Name (First, Middle, Maiden Surname): ETHEL TURNER

19a. Informant's Name/Relationship (Type, Print): LEWIS A. KNIGHT (HUSBAND)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 307 EVA. AVE. LINTHICUM, MARYLAND 21090

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): CHESAPEAKE CREMATORY, INC. Data: 5-23-97
20c. Location - City or Town, State: BELTSVILLE, MARYLAND

21. Signature of Funeral Service Licensee ▶ [signature]
22. Name and Address of Facility: SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Breast cancer with metastasis to Lt Lung	12-9-91
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No
24b. Were autopsy findings available prior to completion of causa of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Cartifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at tha time, date and placa, and dua to the causa(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated.

29b. Signatura and title of certifier ▶ [signature]
29c. Licansa number: D/BJOS
29d. Date signed (Month, Day, Year): 5-22-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Charles J Wu, M.D. 1600 S Crain Hwy # 306 Glen Burnie MD 21061

State Registrar

31. Date filed (Month, Day, Year): MAY 28 1997
32. Registrar's Signature: Julia Davidson Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 17350

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Herman W. Kutun

2. Date of Death — Month: 05 Day: 19 Year: 97

3. Time of Death: 12:45 AM

4a. Facility Name *(If not institution, giva straat and numbar)*: 3212 Britania Court

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 116-14-4314

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 70 Yrs.

If Under 1 Yaar — Months: Days: If Under 24 Hrs. — Hours: Min.:

8. Data of Birth *(Month, Day, Year)*: July 29,1926

9. Birthplace *(Stata or Foraign Country)*: New York

Usual Residanca of Dacedant

10a. Stata: Florida

10b. County: Broward

10c. City, Town or Location: Ft. Lauderdale

10d. Insida City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 5529 Bayview Drive

10f. Zip Coda: 33308

10g. Citizan of What Country?: USA

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☒ Yes 2☐ No — If Yas, Giva Yaar or Datas: W.W. II

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Ricen, atc.): 1☐ Yas 2☒ No *Specify:*

14. Race - Amarican Indian, Black, White, etc. *Specify:* White

15. Decedant's Education *(Specify only highest grade completed)*: Elamantary/Secondary (0-12): 12th; Collaga (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work dona during most of working lifa. DO NOT usa ratired)*: Self Employed Owner

16b. Kind of Businass/Industry: Restaurant

17. Fathar's Nama *(First, Middla, Last)*: William Kutun

18. Mothar's Nama *(First, Middla, Maidan Sumama)*: Rebecca Uzecha

19a. Informant's Name/Ralationship *(Type, Print)*: William M. Kutun/ Son

19b. Mailing Address *(Straat and Number or Rural Routa Numbar, City or Town, Stata, Zip Coda)*: 3212 Britania Ct. Annapolis, Maryland 21403

20a. Mathod of Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramovel from Stata 4☐ Donation 5☐ Othar *(Spacify)*

20b. Placa of Disposition *(Nama of camatary, cramatory or othar placa)*: Metropolitan Crematory — Data: 5-19-97

20c. Location - City or Town, Stata: Alexandria, Virginia

21. Signature of Funeral Service Licensee: ▶ Robert D Kalas

22. Nama and Address of Facility: George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, Md. 21037

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that caused the daath. Do not antar tha moda of dying, such as cardiac or raspiretory arrast, shock, or haart failura. List only one ceusa on aach lina.

Approximata Intarval Batween Onset and Daath

Immadiata Causa (Final disaase or condition resulting in daath)
e. Metastatic Melenoma

Dua to (or as a consequance of):

Sequantially list conditions, if any, leading to immadiata causa. Entar Underlying Causa (Disaase or injury that initiated avants resulting in daath) Last
b.

Dua to (or as a consaquanca of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa givan in Part I.: Aortic Stenosis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to completion of ceusa of daath? 1☐ Yes 2☐ No

25. Was casa rafarrad to medical examiner? 1☐ Yes 2☒ No

26. Placa of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Othar: 4☐ Nursing Home 5☒ Rasidance 6☐ Othar *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Sulcida 4☐ Homicida 5☐ Panding investigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Yaar)*

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28e. Place of Injury - At homa, farm, streat, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examinar**: On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar stated.

29b. Signature and title of certifier: ▶ T Kramella MD

29c. Licensa number: 031778

29d. Data signed *(Month, Day, Year)*: May 19, 1997

30. Nama and address of person who complated causa of daath (Item 23a) (Type, Print): Robert A Miller MD 2003 Medical Parkway Annapolis MD 21401

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Data filed *(Month, Day, Year)*: MAY 21 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17351

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Margaret K. King
2. Date of Death Month: 5 Day: 10 Year: 1997
3. Time of Death: 11:40 AM
4a. Facility Name *(If not institution, give street and number)*: 1001 Market Street
4b. City, Town, or Location of Death: Pocomoke City
4c. County of Death: Worcester

Funeral Director

5. Social Security Number: 218-50-2473
6. Sex: 1☐ M 2☑ F
7. Age *(In yrs. last birthday)*: 44 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 7-19-1952
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Worcester
10c. City, Town or Location: Pocomoke City
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 1001 Market Street
10f. Zip Code: 21851
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☑ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Secretary
16b. Kind of Business/Industry: Pocomoke High School

17. Father's Name *(First, Middle, Last)*: Adron W. Knight
18. Mother's Name *(First, Middle, Maiden Surname)*: Estelle Dickerson

19a. Informant's Name/Relationship *(Type, Print)*: William E. Knight / Brother
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 604 Highland Drive, Eden, N.C. 27288

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Salem Methodist Cemetery
Date: 5-13-97
20c. Location - City or Town, State: Pocomoke, Md.

21. Signature of Funeral Service Licensee: Scott S. Melson
22. Name and Address of Facility: Melson Funeral Home P.O. Box 64, Pocomoke, Md. 21851

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Small Cell Pancreatic

Due to (or as a consequence of):
b. Cancer with Mosaic

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Liver Metastasis and

Due to (or as a consequence of):
d. Subsequent liver failure

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Multiple Sclerosis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)* | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D12893
29d. Date signed *(Month, Day, Year)*: 5-15-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): TERRY P. DETRICH 1405 S. WASHINGTON ST., EASTON, MD. 21601

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 19 1997
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17352

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ivan George Kancev

2. Data of Death: Month 5 Day 19 Year 97

3. Tima of Death: 1CA

4a. Facility Nama (If not institution, giva straat and number): Harford Memorial Hospital

4b. City, Town, or Location of Death: Havre de Grace

4c. County of Death: Harford

Funeral Director

5. Social Security Numbar: 134-58-8114

6. Sax: 1☒M 2☐F

7. Aga (In yrs. last birthday): 60 Yrs.

If Undar 1 Yaar: Months ___ Days ___

If Undar 24 Hrs.: Hours ___ Min. ___

8. Data of Birth (Month, Day, Yaar): Dec. 22, 1936

9. Birthplaca (Stata or Foraign Country): Bulgaria

Usual Rasidance of Decedant

10a. Stata: Maryland

10b. County: Harford

10c. City, Town or Location: Aberdeen

10d. Insida City Limits: 1☒Yas 2☐No

10e. Straat and Number: 41 Pritchard Avenue Apt. A-1

10f. Zip Coda: 21001

10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1☐Navar Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Dacedant Evar in U.S. Armed Forcas? 1☐Yas 2☒No If Yas, Giva Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐Yas 2☒No Specify:

14. Race - Amarican Indian, Black, Whita, atc. Specify: White

15. Dacedant's Education (Specify only highast grada complatad): Elamantary/Sacondary (0-12): 12; Collaga (1-4or 5+): UNK

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratirad): Chef

16b. Kind of Businass/Industry: Diner

17. Fathar's Nama (First, Middle, Last): UNK

18. Mothar's Nama (First, Middla, Maidan Surnama): UNK

19a. Informant's Name/Relationship (Type, Print): Maria E. Kancev (Daughter)

19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 5340 Title Creek Ct., Virginia Beach, VA 23462

20a. Mathod of Disposition: 1☐Burial 2☒Cramation 3☐Ramoval from Stata 4☐Donation 5☐Othar (Specify)

20b. Place of Disposition (Nama of cematary, crematory or othar place): R. A. Ferris & Co., Inc.

Data: 5/21/97

20c. Location - City or Town, Stata: West Chester, PA

21. Signatura of Funaral Sarvica Licensaa: Mary R. DiGiovanni

22. Nama and Addrass of Facility: Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399

Physician /Medical Examiner

23a. Part I. Enter tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina.

Approximata Intarval Batwaan Onsat and Daath

Immadiata Causa (Final disaasa or condition resulting in death)
a. acute MI

Dua to (or as a consequence of):
b. ischemic bowel

Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disaasa or injury that initiated events rasulting in daath) Last
Dua to (or as a consequance of):
c. lupus

Dua to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha undarlying ceusa givan in Part I.

CVA - Hyp C

COPD - CARDIOMYOPATHY

RENAL FAILURE - ND

23b. Did tobacco use contribute to the cause of death? 1☐Yas 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yas 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yas 2☒No

25. Was ceca referred to madical axaminer? 1☐Yas 2☒No

26. Placa of Daath (Check only ona)
Hospital: 1☒Inpatiant 2☐ER/Outpatient 3☐DOA
Othar: 4☐Nursing Homa 5☐Rasidance 6☐Othar (Specify)

27. Manner of Death: 1☒Naturel 2☐Accidant 3☐Sulcida 4☐Homicida 5☐Pending investigation 6☐Could not be datarmined

28a. Data of Injury (Month, Day Yaar)

28b. Tima of Injury M

28c. Injury at Work? 1☐Yas 2☐No

28d. Dascribe how injury occurred

28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify)

28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifiar (Check only one) 1☐ **Cartifying Physician:** To tha bast of my knowladga, daath occurred at tha tima, data and placa, and dua to the ceusa(s) and manner as stated. 2☐ **Madical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and placa, and dua to tha cause(s) and mannar statad.

29b. Signature and title of certifier: I. Hanoo MD

29c. Licansa number: D42800

29d. Date signed (Month, Day, Yaar): 5/19/97

30. Nama and addrass of person who completed ceusa of daath (Item 23a) (Type, Print): I. Hanoo MD, UMC, 3195 Calvert Ave, Add., MD, 21078

State Registrar

31. Data filed (Month, Day, Yaar): MAY 21 1997

32. Registrar's Signatura: Julie Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Kancev, Ivan George died 5/19/97 11 AM

1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17353

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WARREN EDWARD KRUMKE

2. Date of Death Month Day Year: APRIL 30, 1997

3. Time of Death: 11:50 PM

4a. Facility Name (If not institution, give street and number): St. Mary's Hospital

4b. City, Town, or Location of Death: Leonardtown

4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 579-28-5873

6. Sex: 1 ■ M 2 ☐ F

7. Age (In yrs. last birthday): 70 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 20, 1926

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: St. Mary's

10c. City, Town or Location: Tall Timbers

10d. Inside City Limits: 1 ☐ Yes 2 ■ No

10e. Street and Number: 45006 Tall Timbers Road, P.O. Box 135

10f. Zip Code: 20690

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ■ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ■ Yes 2 ☐ No If Yes, Give Year or Dates: WW11

13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ■ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Supervisor

16b. Kind of Business/Industry: U.S. Defense

17. Father's Name (First, Middle, Last): Karl Ernest Krumke, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Ida Melissa Cox

19a. Informant's Name/Relationship (Type, Print): Charlotte Z. Krumke, Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 45006 Tall Timbers Road, P.O. Box 135, Tall Timbers, MD 20690

20a. Method of Disposition: 1 ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. George's Episcopal Cemetery

Date: 5-4-97

20c. Location - City or Town, State: Valley Lee, Maryland

21. Signature of Funeral Service Licensee: Edward N. Brinsfield, Jr., M00052

22. Name and Address of Facility: Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, Maryland 20650-0279

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory failure — 2 weeks

Due to (or as a consequence of):

b. Pleural effusion & Pneumonia — 2 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. End stage renal disease — long time

Due to (or as a consequence of):

d. Coronary artery disease — long time

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ A Shah M.D.

29c. License number: D47066

29d. Date signed (Month, Day, Year): 5-1-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Avani Shah, M.D., Medical Arts Building, Leonardtown, Maryland 20650

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): MAY 02 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17354

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CHARLES WESLEY KITCHEN
2. Date of Death Month: MAY Day: 21 Year: 1997
3. Time of Death: 9:40 PM
4a. Facility Name *(If not institution, give street and number)*: 6553 KING ROAD
4b. City, Town, or Location of Death: BOONSBORO
4c. County of Death: WASHINGTON

Funeral Director

5. Social Security Number: 220-16-0559
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 74 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: AUG. 19, 1922
9. Birthplace *(State or Foreign Country)*: WEST VIRGINIA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: WASHINGTON
10c. City, Town or Location: BOONSBORO
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6553 KING ROAD
10f. Zip Code: 21713
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1942-1945
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6 / College (1-4or 5+):
18a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: MILLWRIGHT
16b. Kind of Business/Industry: METAL BUILDING MANUF.

17. Father's Name *(First, Middle, Last)*: WESLEY KIMBLE KITCHEN
18. Mother's Name *(First, Middle, Maiden Surname)*: JANIE CATHERINE SNYDER

19e. Informant's Name/Reletionship *(Type, Print)*: ESTHER I. KITCHEN/SPOUSE
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6553 KING ROAD, BOONSBORO, MARYLAND 21713

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: BOONSBORO CEMETERY
Date: 5/24/97
20c. Location - City or Town, State: BOONSBORO, MARYLAND

21. Signature of Funeral Service Licensee: ▶ Paul M. Dean — Paul M. Dean
22. Name and Address of Facility: BAST FUNERAL HOME, 7606 Old National Pike, Boonsboro, Maryland 21713

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Liver Metastasis. — 8 months.
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Abdominal Leiomyosarcoma. — 2 years
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 8☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Hyd Hamdan
29c. License number: D46473
29d. Date signed *(Month, Day, Year)*: May 22, 1997
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Hyd Hamdan, MD — 363 S. Cleveland Ave. Hagerstown MD 21740

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 23 1997
32. Registrar's Signature: ▶ Julia Hudson Parker

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17355

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ARLENE RENA KUHN

2. Date of Death Month: May Day: 18 Year: 1997

3. Time of Death: 1050

4a. Facility Name *(If not institution, give street and number)*: Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 215-18-2201

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 76 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: May 12, 1921

9. Birthplaca *(Stata or Foreign Country)*: Maryland

Usual Rasidance of Dacedant

10a. Steta: Maryland

10b. County: Frederick

10c. City, Town or Location: Sabillasville

10d. Insida City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 4638 Foxville Road

10f. Zip Coda: 21780

10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Naver Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armad Forces? 1☐ Yes 2☒ No If Yas, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1☐ Yas 2☒ No *Specify:*

14. Race - Amaricen Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highast grada complatad)*: Elamantary/Secondary (0-12): 7th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT use retired)*: Domestic

16b. Kind of Businass/Industry: Cleaning

17. Fathar's Nama *(First, Middla, Last)*: Frank H. Kuhn

18. Mothar's Neme *(First, Middla, Maidan Surname)*: Rena E. Buhrman

19a. Informant's Name/Ralationship *(Type, Print)*: Jill A. Brown, daughter

19b. Mailing Addrass *(Streat and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 4638 Foxville Road Sabillasville, MD 21780

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Nama of cematary, cramatory or othar place)*: Mt. Bethel Cemetery

Data: 5/21/97

20c. Location - City or Town, Steta: Foxville, Maryland

21. Signature of Funaral Service Licensee: Penny Ro Savage

22. Nama and Address of Facility: Stauffer Funeral Homes, P.A. 104 East Main Street Thurmont, MD 21788

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the death. Do not antar tha mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only ona ceusa on aach lina.

		Approximate Interval Between Onsat and Death
Immediate Causa (Final disaasa or condition rasulting in daath) e.	Congestive Heart Failure	2 weeks
Due to (or as a consaquance of): b.	Myocardial infarction	3 weeks
Sequantially list conditions, if any, leading to immadiate ceusa. Enter Undarlying Causa (Disaasa or Injury thet Initiated avents rasulting in daath) Last. Due to (or as a consaquance of): c.	Coronary artery disease	Unknown
d.		

Part II. **Other significent conditiona** contributing to daath but not resulting in tha undarlying cause givan in Part I.: Cerebrovascular Accident; Atrial Fibrillation; Diabetes mellitus

23b. Did tobacco usa contributa to tha cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performad? 1☐ Yas 2☑ No

24b. Wara autopsy findings available prior to complation of ceuse of daath? 1☐ Yas 2☐ No

25. Was cesa raferred to medicel examiner? 1☐ Yas 2☑ No

26. Piece of Death *(Check only ona)*: Hospital: 1☑ Inpatiant 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not ba datarmined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, straat, factory, office building, atc. *(Specify)*

28f. Location *(Straet and Number or Rural Routa Numbar, City or Town, Steta)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, daath occurred at the time, dete end piece, and due to the ceusa(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of exeminetion and/or invastigetion, in my opinion, daath occurred at tha tima, data and piece, end due to the ceuse(s) and mannar statad.

29b. Signatura and tila of certifiar

29c. Licansa number: D44996

29d. Data signed *(Month, Day, Year)*: May 19, 1997

30. Nama and addrass of person who completed cause of death (Item 23e) (Type, Print): ZAFAR MALIK MD 20311 LAPPANS RD BOONSBORO MD 21713

State Registrar

31. Data filed *(Month, Day, Year)*: MAY 20 1997

32. Registrar's Signatura: Gabi Davidson Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Kuhn, Arlene Rena

97 17356

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Robert C. Kerns			2. DATE OF DEATH (Month, Day, Year): May 16, 1997	3. TIME OF DEATH: 1930 M
4. SOCIAL SECURITY NUMBER: 176-03-2411	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 85 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Mar 29, 1912	8. BIRTHPLACE (State or Foreign Country): PA
9a. FACILITY NAME (If not institution, give street and number): Allegany Co. Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland	9c. COUNTY OF DEATH: Allegany	

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Allegany	10c. CITY, TOWN OR LOCATION: Cumberland	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 103 Virginia Avenue		10f. ZIP CODE: 21502	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5 +):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Retired Employee	16b. KIND OF BUSINESS/INDUSTRY: Railroad	
17. FATHER'S NAME (First, Middle, Last): John Bruce Kerns		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary E. (Evans)	
19a. INFORMANT'S NAME (Type/Print): Lisa Hill- Soc. Worker	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 730 Furnace Street Ext. Cumberland MD 21502		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, other place): Green Ridge Cemetery	DATE: 05/27	20c. LOCATION — City or Town, State: Connellsville, PA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Nicholas J Scarpelli	22. NAME AND ADDRESS OF FACILITY: Scarpelli Funeral Home Cumberland, MD 21502		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. HYPERKALEMIA	2 days.
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated evente resulting in death) LAST	b. CHRONIC RENAL FAILURE	2 months
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Ca. of Prostate, severe anemia, S/P CVA, Korsakoff's encephalopathy.

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [X] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: V. A. Ranjithan	29c. LICENSE NUMBER: D19750	29d. DATE SIGNED (Month, Day, Year): May. 19, 1997.
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. V.A. Ranjithan 730 Furnace St. Ext. Cumberland MD 21502		
31. DATE FILED (Month, Day, Year): MAY 22 1997	32. REGISTRAR'S SIGNATURE: Julia Dawson Randall	

DHMH-18 Rev 1/89

Amended # 25, 5/19/97
MAS, Allegany County

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17357

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
HENRY H. KNIERIEM	MAY 15 1997	21:33

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Sacred Heart Hospital	Cumberland	Allegany

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Dey, Year)	9. Birthplace (State or Foreign Country)
214-05-9764	1☒ M 2☐ F	87 Yrs.			01-Jul-09	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. Stete	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Allegany	Frostburg	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
84 Walnut Street	21532-	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grede completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8	0	Truck tire builder	tire manufacturing

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surneme)
Charles Knieriem	Edna E. Llewellyn

19a. Informant's Name/Relationship (Type, Print)		19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)			
Paul Knieriem	Son	114 Walnut Street	Frostburg	Maryland	21532-

20a. Method of Disposition	20b. Place of Disposition (Neme of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Frostburg Memorial Park	18-May-97	Frostburg, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
John R. Durst	Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line.

		Approximate Interval Between Onset end Death
Immediate Cause (Finel disease or condition resulting in death)	a. Coronary Artery Disease	20 yrs
Due to (or es e consequence of):	b. Hypertension	20 yrs
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in death) Last	c. COPD	20 yrs
Due to (or es e consequence of):	d.	

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings eveileble prior to completion of cause of deeth?
1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown	1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Deeth (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☐ Inpatient 2☒ ER/Outpetient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how Injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as steted.
2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
Angel H. Roque M.D.	D 13166	MAY 16, 1997

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)
ANGEL H. ROQUE M.D. 48 Tara Terrace Frostburg Md.

State Registrar

31. Date filed (Month, Dey, Year)	32. Registrar's Signature
MAY 19 1997	[illegible]

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after deeth.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit permit. Pages 1 and 2 should be filed within 72 hours eftar deeth with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

4
MAS

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17358

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Augustine Landy Kidwell

2. Date of Death Month Day Year: May 22, 1997

3. Time of Death: 8:50 AM

4a. Facility Name *(If not institution, give street and number)*: 9202 Goldenrod Lane

4b. City, Town, or Location of Death: Upper Marlboro

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577-07-9757

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Aug 9, 1912

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Upper Malrboro

10d. Inside City Limits: 1 [ ] Yes [X] No

10e. Street and Number: 9202 Goldenrod Lane

10f. Zip Code: 20772

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1941 1941

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Mechanic

16b. Kind of Business/Industry: Exxon

17. Father's Name *(First, Middle, Last)*: William L. Kidwell

18. Mother's Name *(First, Middle, Maiden Surname)*: Augusta Duvall

19a. Informant's Name/Relationship *(Type, Print)*: Madeline Alberta Kidwell

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9202 Goldenrod Lane, Upper Marlboro, Maryland 20772

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: May 28, 1997

20c. Location - City or Town, State: Maryland States Veterans Cemetery Cheltenham, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Lee Funeral Home, Inc 6633 Old Alexandria Ferry Rd, Clinton, Md 20735

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARCINOMA of PROSTATE — 3YRS.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D46478

29d. Date signed *(Month, Day, Year)*: 5-23-97.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Patel, 7501 Surratts Road, Clinton, Maryland 20735

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 27 1997

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17359

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edith Larue
2. Date of Death (Month, Day, Year): May 17 1997
3. Time of Death: 430 AM
4a. Facility Name (If not institution, give street and number): Howard County Hospital
4b. City, Town, or Location of Death: Columbia
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 578-01-0410
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 14, 1910
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Columbia
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 6334 Cedar Lane
10f. Zip Code: 21044
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Nevar Married 2☐ Merried 3☒ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Give Year or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puarto Rican, atc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Bieck, White, atc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 11 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cafeteria Manager
16b. Kind of Business/Industry: School
17. Fathar's Nama (First, Middla, Last): Charles A. Harvey
18. Mother's Name (First, Middle, Melden Sumema): Annie Clark
19a. Informent's Neme/Reletionship (Type, Print): Priscilla L. Platnik / Daughter
19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code): 1 Brighton Knolls Court, Brinklow, Maryland 20862
20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Ramovel from Stete 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cametery, cremetory or other place): Union Cemetery | Dete: 5/20/97
20c. Location - City or Town, State: Burtonsville, Maryland
21. Signature of Funeral Service Licensee: Thomas Guyer
22. Name end Addrass of Facility: Hines-Rinaldi Funeral Home, 11800 New Hampshire Avenue, Silver Spring, Maryland 20904

Physician /Medical Examiner

23e. Pert1. Enter tha diseese, or complications that caused the deth. Do not enter the moda ot dying, such es cardiac or respiretory errest, shock, or heert teilure. List only one cause on each line. — Approximete Intervel Between Onset and Death

Immediete Cause (Finel disease or conditlon resulting in deeth): e. Pneumonia — 5 days
Due to (or es e consequence of):
Sequentielly list conditions, If any, leading to immedieta causa. Entar Underlying Cause (Diseesa or Injury thet Initieted events rasulting in death) Lest:
b. Due to (or as a consequence of):
c. Due to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I. Delay Interment

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Ware autopsy tindings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Wes case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Deeth (Check only one): Hospitel: 1☑ Inpatient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Homa 5☐ Rasidance 6☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending invastigation 6☐ Could not be determined
28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, ferm, straat, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To tha bast ot my knowledge, deeth occurred et the time, dete and plece, end dua to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis ot examinetion end/or investigation, in my opinion, deeth occurred et tha time, dete end plece, and due to tha causa(s) end manner steted.
29b. Signeture end titla ot cartitier: Bruce Conger Internist
29c. License number: D37013
29d. Dete signed (Month, Dey, Year): May 17, 1997
30. Neme end eddrass ot person who completed cause of deeth (Item 23a) (Type, Print): B CONGER, MD #210 11055 Little Patuxent Pkwy, Columbia, MD 21044

State Registrar

31. Data tiled (Month, Dey, Year): MAY 20 1997
32. Registrar's Signature: [illegible] Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

15

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17360

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Bertha Silverstein Lederman

2. Date of Death: Month May Day 16 Year 1997

3. Time of Death: 22 15

4a. Facility Name *(If not institution, give street and number)*: 3307 Shirley Lane

4b. City, Town, or Location of Death: Chevy Chase

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 052-52-2042

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 16,1905

9. Birthplace *(State or Foreign Country)*: Russia

Usual Residance of Decedant

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Chevy Chase

10d. Insida City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 3307 Shirley Lane

10f. Zip Coda: 20815

10g. Citizen of What Country?: U.S.A.

11. Meritel Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U,S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yeer or Datas:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*

14. Race - American Indlen, Black, White, atc. *Specify:* White

15. Decedent's Education *(Specify only highast grade completed)*: Elamantary/Secondary (0-12): 12 | Collega (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working lifa. DO NOT usa retired)*: Housewife

16b. Kind of Business/Industry: Own Home

17. Fethar's Nama *(First, Middla, Last)*: Abraham Silverstein

18. Mothar's Nama *(First, Middla, Maiden Surname)*: Lily Silverstein

19a. Informant's Name/Ralationship *(Type, Print)*: Norma Kramer

19b. Mailing Address *(Straat and Number or Rural Routa Number, City or Town, Stete, Zip Coda)*: 3307 Shirley Lane,Chevy Chase,Maryland 20815

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Piece of Disposition *(Nama of cemetary, crematory or other place)*: Wellwood Cemetery

Data: May 19, 1997

20c. Location - City or Town, Stete: Long Island,New York

21. Signature of Funeral Service Licensee: Peter R. Hamm

22. Nama and Address of Facility: Ives-Pearson Funeral Homes 2847 Wilson Blvd.,Arlington,Virginia 22201

Physician /Medical Examiner

23a. Part1. Enter tha disaasa, or complications that caused the death. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only ona cause on aach lina.

Approximata Intarval Between Onset and Death

Immediata Causa (Final diseasa or condition resulting in death)
a. Intestinal obstruction — 3 months

Dua to (or as a consequence of):
b. Intestinal adhesions — 6 months

Sequentially list conditions, if eny, laeding to immadiata cause. Entar Underlying Cause (Disaasa or injury that initiated evants resulting in death) Last

Dua to (or as a consequance of):
c. Diverticulitis — 2 years

Dua to (or as a consequance of):
d. Diverticulosis — 5 years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa givan in Part I.

Pulmonary edema

Cerebrovascular insufficiency

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☑ No

24b. Wara autopsy findings available prior to completion of causa of death? 1☐ Yas 2☐ No

25. Was casa rafarred to medical examinar? 1☐ Yas 2☑ No

26. Placa of Death *(Check only ona)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Othar: 4☐ Nursing Homa 5☑ Rasidance 6☐ Othar *(Specify)*

27. Manner of Deeth: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Panding investigation 6☐ Could not be detarmined

28a. Data of Injury *(Month, Dey Year)*

28b. Tima of injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Place of Injury - At home, farm, streat, factory, office building, atc. *(Specify)*

28f. Location *(Straat and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifiar *(Check only one)*: 1☑ **Certifying Physician:** To tha best of my knowledga, daath occurred at tha time, dete end plece, end due to the cause(s) end manner as steted. 2☐ **Medical Examinar:** On tha basis of axamination and/or investigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha causa(s) and manner stated.

29b. Signature and title of certifier: Stephen R. Kay MD

29c. License number: D27258

29d. Dete signed *(Month, Day, Year)*: May 17 1997

30. Nama and address of person who completed causa of death (Item 23a) (Type, Print): STEPHEN R. KAY MD 5530 WISCONSIN AVE., CHEVY CHASE MD

State Registrar

31. Data filed *(Month, Day, Year)*: MAY 19 1997

32. Registrar's Signatura: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17361

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ethel Corbett Leuvelink
2. Date of Death Month Day Year: May 15, 1997
3. Time of Death: 2:30 PM
4a. Facility Name *(If not institution, give street and number)*: 107 Williamsburg Drive
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 154-36-9011
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 89 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: March 2, 1908
9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: Florida
10b. County: Dade
10c. City, Town or Location: Miami Beach
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1750 James Avenue, Apt. 10D
10f. Zip Code: 33139
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Michael Corbett
18. Mother's Name *(First, Middle, Maiden Surname)*: Antoinette Skarka

19a. Informant's Name/Relationship *(Type, Print)*: Ronald Bernard Leuvelink
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 107 Williamsburg Drive, Silver Spring, MD 20901

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Chesapeake Crematory
Date: 5-17-97
20c. Location - City or Town, State: Beltsville, Maryland

21. Signature of Funeral Service Licensee: Ellen W. Rapp
22. Name and Address of Facility: Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Carcinoma of Uterus — 2 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Multi micro infarct dementia

Arteriosclerotic heart disease with pacemaker

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 8☒ Other *(Specify)* Son's Home

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jeremy V Cooke
29c. License number: D 04602
29d. Date signed *(Month, Day, Year)*: May 19, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jeremy V. Cooke, M. D. — 10400 Connecticut Avenue, #606 Kensington, MD 20895

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 19 1997
32. Registrar's Signature: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17362

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Cavell B. LoPresti
2. Date of Death Month Day Year: May 16, 1997
3. Time of Death: 10:41 AM
4a. Facility Name *(If not institution, give street and number)*: Montgomery General Hospital
4b. City, Town, or Location of Death: Olney
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-07-3244
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 77 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 26, 1919
9. Birthplace *(State or Foreign Country)*: Washington, DC

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Chevy Chase
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3403 Kenilworth Driveway
10f. Zip Code: 20815
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Secretary
16b. Kind of Business/Industry: Dept. of Defense

17. Father's Name *(First, Middle, Last)*: Samuel Bartlett
18. Mother's Name *(First, Middle, Maiden Surname)*: Ada Belcher

19a. Informant's Name/Relationship *(Type, Print)*: S. Joseph LoPresti
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 11011 Old Coach Road, Potomac, MD 20854

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Fort Lincoln Cemetery
Date: 5-19-97
20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: ▶ Ellen W. Rapp
22. Name and Address of Facility: Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Respiratory failure

Due to (or as a consequence of):
b. Bilateral Aspiration Pneumonia — 2-3 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Septicemia.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Acute Pancreatitis.
Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Murarka, MD
29c. License number: D29816
29d. Date signed *(Month, Day, Year)*: MAY 16, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RADHEY MURARKA, 50 WEST EDMONSTON DRIVE ROCKVILLE MD

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 19 1997
32. Registrar's Signature: Gina Davidson-Randall

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

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DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended #17, 5/21/97, JW, Mont. Co. *Certificate of Death*

Reg. No. 97 17363

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ANGELA M. LARDIES
2. Date of Death Month: MAY Day: 15 Year: 1997
3. Time of Death: 0945AM
4a. Facility Name *(If not institution, give street and number)*: SHADY GROVE ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 219-64-7485
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 70 Yrs. If Under 1 Year Months / Days; If Under 24 Hrs. Hours / Min.
8. Date of Birth *(Month, Day, Year)*: MARCH 30, 1927
9. Birthplace *(State or Foreign Country)*: ARGENTINA

Usual Residence of Decedent

10a. State: MD.
10b. County: MONTGOMERY
10c. City, Town or Location: ROCKVILLE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 342 NEW MARK ESPLANADE
10f. Zip Code: 20850
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☒ Yes 2☐ No *Specify:* ARGENTINIAN
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER
16b. Kind of Business/Industry: AT HOME

17. Father's Name *(First, Middle, Last)*: Antonio Lardies ~~ANGELINA~~ ~~MUNOZ~~ ~~JOFRE~~
18. Mother's Name *(First, Middle, Maiden Surname)*: ANGELINA MUNOZ JOFRE

19a. Informant's Name/Relationship *(Type, Print)*: MARTIN DeVINCENTI/SON
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10304 PARKWOOD DR., KENSINGTON, MD. 20895

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: CHAMBERS CREMATORY
Date: 5/17
20c. Location - City or Town, State: RIVERDALE, MD.

21. Signature of Funeral Service Licensee: W. W. Chambers
M00091
22. Name and Address of Facility: CHAMBERS FUNERAL HOMES, P.A., SILVER SPRING, MD. 20910

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CEREBROVASCULAR ACCIDENT — 12 DAYS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ASPIRATION PNEUMONIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

28. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: JW
29c. License number: D 29256
29d. Date signed *(Month, Day, Year)*: May 15, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOSE A. QUIROS MD 4343 Montgomery Av Bethesda Md 20814

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 19 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

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To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17364

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mildred E. Labraico

2. Date of Death Month Dey Year: May 16, 1997

3. Time of Death: 5:30pm

4e. Facility Name (If not institution, give street and number): 18704 Capella Lane

4b. City, Town, or Location of Death: Gaithersburg

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 172-26-6840

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 89 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Year): July 25, 1907

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Gaithersburg

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street end Number: 18704 Capella Lane

10f. Zip Code: 20877

10g. Citizen of What Country?: United States

11. Maritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒No If Yes, Give Year or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 2

16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Nurse

16b. Kind of Business/Industry: Nursing

17. Fether's Name (First, Middle, Last): John J. Meikrantz

18. Mother's Name (First, Middle, Maiden Sumame): Mary Edwards

19a. Informant's Name/Relationship (Type, Print): Carole Celler

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 18704 Capella Lane, Gaithersburg, MD 20877

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☒Removal from State 4☐Donetion 5☐Other (Specify)

20b. Placa of Disposition (Neme of cemetery, cremetory or other place): Vine Street Cemetery

Date: 5/20/97

20c. Location - City or Town, State: Hazelton, Pennsylvania

21. Signeture of Funeral Service Licensee: Michael D Gibbons

22. Name and Address of Feciility: DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877

To Be Completed by Funeral Director

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heert feilure. List only one ceuse on each line.

Approximate Interval Between Onset end Death

Immediete Ceuse (Finel disease or condition resulting in death): e. Congestive Heart Failure — One Year

Due to (or es a consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Last

b. Due to (or as a consequenca of):

c. Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒No

24b. Were autopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residenca 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) end manner as stated. 2☐ **Medical Examiner**: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and placa, and due to the cause(s) and menner stated.

29b. Signature end title of certifier: Christy Lyst MD

29c. License number: D 31839

29d. Date signed (Month, Day, Year): May 17, 1997

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print): Christopher Dunford, MD, 615 West Montgomery Avenue, Rockville, Maryland 20850

State Registrar

31. Date filed (Month, Day, Year): MAY 21 1997

32. Registrar's Signature: Gisha Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17365

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Lawrence J. LaCharity
2. Date of Death Month Day Year: May 16, 1997
3. Time of Death: 2:00PM
4a. Facility Name *(If not institution, give street and number)*: 8820 Burdette Road
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-38-2815
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 91 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jan. 10, 1906
9. Birthplace *(State or Foreign Country)*: Wisconsin

Usual Residance of Decedant

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1 [ ] Yas 2 [X] No
10e. Street and Numbar: 8820 Burdette Road
10f. Zip Coda: 20817
10g. Citizan of What Country?: United States

11. Marital Status: 1 [ ] Navar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Dacedant Evar in U.S. Armed Forcas? 1 [ ] Yas 2 [X] No — If Yas, Giva Yaar or Datas:
13. Was Dacedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1 [ ] Yas 2 [X] No *Specify:*
14. Race - American Indian, Black, White, atc. *Specify:* White

15. Decedant's Education *(Specify only highast grada complatad)*: Elamantary/Secondary (0-12): 12 — Collega (1-4or 5+):
16a. Decedant's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratirad)*: Court Reporter
16b. Kind of Business/Industry: Self Employed

17. Fathar's Nama *(First, Middle, Last)*: Joseph LaCharity
18. Mothar's Nama *(First, Middle, Maiden Surname)*: Selma Gustafson

19a. Informant's Name/Ralationship *(Type, Print)*: Sandra J. LaCharity/Daughter
19b. Mailing Address *(Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 7605 S. 88th Street, LaVista, Nebraska 68128

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Othar *(Specify)*
20b. Place of Disposition *(Nama of cematary, cramatory or othar place)*: Drummer Township Cemetery — Data: May 22, 1997
20c. Location - City or Town, Stata: Gibson City, Illinois

21. Signatura of Funaral Sarvice Licensaa: Richard P. Kutta M00348
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused the daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or heart failura. List only one ceusa on aach lina. — Approximata Intarval Batwaan Onsat and Daath

Immadiata Causa (Final disaasa or condition rasulting in daath)
a. Pneumonia — 10 Days
Dua to (or as e consequance of):
b. Glioblastoma of Left Temporal Lobe of Brain — 8 weeks

Sequantially list conditions, if any, laading to Immadiata causa. Entar Undarlying Causa (Disaasa or injury thet initiatad avants rasulting in daath) Last
Dua to (or as a consaquanca of):
c.
Dua to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] **Yes** 2 [X] **No** 3 [ ] **Probably** 4 [ ] **Unknown**

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No
24b. Wara autopsy findings availeble prior to compiation of causa of daath? 1 [ ] Yas 2 [X] No

25. Was casa rafarrad to medical examiner? 1 [ ] Yes 2 [X] No
26. Placa of Daath *(Check only ona)* — Hospital: 1 [ ] Inpatiant 2 [ ] ER/Outpatiant 3 [ ] DOA — Other: 4 [ ] Nursing Homa 5 [X] Rasidance 6 [ ] Other *(Specify)*

27. Mannar of Death: 1 [X] Natural 2 [ ] Accidant 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Panding Invastigation 6 [ ] Could not be datarmined
28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. *(Specify)*
28b. Tima of Injury
28c. Injury at Work? 1 [ ] Yas 2 [ ] No
28d. Dascribe how injury occurred
28e. Data of Injury *(Month, Day Yaar)*
28f. Location *(Straat and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifiar *(Check only one)*: 1 [X] **Certifying Physician:** To tha best of my knowledga, daath occurrad at the time, data and placa, and dua to tha cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of axamination and/or invastigation, in my opinion, daath occurrad at the time, data and placa, and dua to tha cause(s) and mannar statad.
29b. Signatura and tita of certifiar: Lawrence H. Schainker M.D.
29c. Licansa number: D14459
29d. Data signed *(Month, Day, Year)*: May 16, 1997

30. Nama and addrass of parson who completed cause of daath (Item 23a) (Type, Print): Lawrence H. Schainker, M.D., 5401 Western Avenue, N.W., Washington, DC 20015

State Registrar

31. Data filed *(Month, Day, Year)*: MAY 21 1997
32. Registrar's Signatura: [illegible]

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17366

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RICHARD Upsher LEWIS

2. Date of Death Month Day Year: May 22, 1997

3. Time of Death: 3:35 PM

4a. Facility Name (If not institution, give street and number): Salisbury Center Genesis ElderCare

4b. City, Town, or Location of Death: Salisbury, Md.

4c. County of Death: Wicomico

Funeral Director

5. Social Security Number: 221-12-8681

6. Sex: 1 X M 2 ☐ F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb.3 1918

9. Birthplace (State or Foreign Country): W.Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Wicomico

10c. City, Town or Location: Salisbury

10d. Inside City Limits: 1 ☐ Yes 2 X No

10e. Street and Number: 603 Dennis Street

10f. Zip Code: 21801

10g. Citizen of What Country? U.S.A

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:

14. Reca - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer

16b. Kind of Business/Industry: None

17. Father's Name (First, Middle, Last): John Spencer Lewis

18. Mother's Name (First, Middle, Maiden Surname): Harriett Harrison

19a. Informant's Name/Relationship (Type, Print): Carol McCoy (Daughter Grand)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 509 Truitt St.Salisbury,Md.21801

20a. Method of Disposition: 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Salisbury Crematory

Date: 5-27-97

20c. Location - City or Town, State: Salisbury,Md.

21. Signature of Funeral Service Licensee: ▶ Gladys B, Stewart

22. Name and Address of Facility: Stewart Funeral Home 821 West Rd.Salisbury,Md.21801

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Complications of Dementia — YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as e consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ASCVD, CHF

Urine outflow obstruction, Hx MRSA in urine

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No

24b. Were autopsy findings availeble prior to completion of cause of death? 1 ☐ Yes 2 X No

25. Was cese referred to medical examiner? 1 ☐ Yes 2 X No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and menner es stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature end title of certifier: ▶

29c. License number: D-39813

29d. Date signed (Month, Dey, Year): 5/25/97

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print): MICHAEL ATIKINS, 1104 HEALTHWAY DR., SALISBURY, MD. 21804

State Registrar

31. Date filed (Month, Day, Year): MAY 27 1997

32. Registrar's Signature: ▶ Judy Davidson Randall

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17367

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: John Turner Lutz, Jr.

2. Data of Death Month / Dey / Yaar: May 20, 1997

3. Time of Death: 7:00 pm

4e. Facility Nema *(If not institution, give street end number)*: Chesapeake Healthcare

4b. City, Town, or Location of Death: Arnold

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 218-07-3633

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 83 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Deta of Birth *(Month, Day, Year)*: Mar 20,1914

9. Birthpleca *(Stata or Foreign Country)*: Maryland

Usual Rasidance of Decedant

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Severna Park

10d. Insida City Limits: 1☐Yes 2☒No

10a. Street and Number: 245 Cypress Creek Road

10f. Zip Code: 21146

10g. Citizen of What Country?: USA

11. Maritel Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1☒Yas 2☐No If Yes, Give Yaar or Datas: 1943-54

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highast grade completed)*: Elamantery/Secondary (0-12): 12 / Collega (1-4or 5+):

16a. Dacedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT usa retired)*: Sales

16b. Kind of Businass/Industry: Hardware

17. Father's Name *(First, Middla, Last)*: John Turner Lutz, Sr.

18. Mothar's Nama *(First, Middle, Maiden Surneme)*: Theresa Krepein

19a. Informant's Name/Relationship *(Type, Print)*: Barbara Lutz-Heiman/daughter

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 247 Cypress Creek Rd., Severna Park, MD 21146

20a. Mathod of Disposition: 1☐Burial 2☒Cramation 3☐Removal from State 4☐Donation 5☐Other *(Spacify)*

20b. Placa of Disposition *(Nema of cemetary, cramatory or other place)*: Metro Crematory

Date: May 22 1997

20c. Location - City or Town, Stata: Baltimore, MD

21. Signature of Funeral Service Licensee: [signature]

22. Nama and Address of Facility: Barranco & Sons, P.A. Severna Park Funeral Home 495 GovRitchie Hwy., Severna Park, MD 21146

Physician /Medical Examiner

23a. Part I. Enter the disaasa, or complications that caused the deeth. Do not antar the moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona ceusa on each line.

Approximate Interval Batween Onsat and Death

Immediata Causa (Finel disaase or condition resulting in death): a. End Stage Chronic Obstructive Pulmonary Disease — several year

Dua to (or as a consequence of):

Sequantially list conditions, if any, leading to immadiata causa. Entar Underlying Causa (Disaasa or Injury that Initiated avants resulting in deeth) Lest:

b.

Dua to (or as a consequanca of):

c.

Due to (or es e consequanca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Ware autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case refarred to medical examinar? 1☐Yes 2☒No

26. Placa of Daath *(Check only ona)*: Hospital: 1☐Inpatiant 2☐ER/Outpatiant 3☐DOA Other: 4☒Nursing Homa 5☐Rasidanca 6☐Othar *(Specify)*

27. Manner of Deeth: 1☒Natural 2☐Accidant 3☐Suicida 4☐Homicida 5☐Pending Investigetion 6☐Could not be determined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Dascribe how injury occurred

28e. Pleca of Injury - At homa, farm, straet, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒**Certifying Physician**: To the best of my knowledga, daeth occurred at the time, dete end plece, end dua to the causa(s) end manner as stated. 2☐**Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar stated.

29b. Signatura and titla of certifier: [signature] MD

29c. Licansa number: D-40521

29d. Data signed *(Month, Day, Year)*: May 22,1997

30. Nama and address of person who completed causa of death (Itam 23a) (Type, Print): DR MAHESH S. OCHANEY 7845 OAKWOOD ROAD SUITE 205 GLEN BURNIE, MD 21061

State Registrar

31. Data filad *(Month, Day, Year)*: MAY 27 1997

32. Registrar's Signatura: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17368

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Roger H. Logan

2. Date of Death Month May Day 20, Year 1997

3. Time of Death: 0750

4a. Facility Name *(If not institution, give street and number)*: 21 Joseph Gallagher Street

4b. City, Town, or Location of Death: Elkton

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 220-07-9186

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 77 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct. 4, 1919

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedant

10a. State: Maryland

10b. County: Cecil

10c. City, Town or Location: Elkton

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 21 Joseph Gallagher Street

10f. Zip Code: 21921

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1941-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Project Manager

16b. Kind of Business/Industry: Engineering & Construction, U. of Delaware

17. Father's Name *(First, Middle, Last)*: Clarence C. Logan

18. Mother's Name *(First, Middle, Maiden Surname)*: Dora L. Goodnow

19a. Informant's Name/Relationship *(Type, Print)*: Marie Y. Logan - Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 21 Joseph Gallagher Street - Elkton, MD 21921

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: North East Meth. Cemetery

Date: 5-23 1997

20c. Location - City or Town, State: North East, Maryland

21. Signature of Funeral Service Licensee: Donald S. Hicks

22. Name and Address of Facility: Hicks Home for Funerals, P.A. 103 W. Stockton Street - Elkton, MD 21921-5521

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Carcinoma of the lung

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Congestive heart failure

Due to (or as a consequence of):

c. Dilated cardiomyopathy

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*: 5/2

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Kevin Corrin MD

29c. License number: 02884

29d. Date signed *(Month, Day, Year)*: 5/22/97

30. Name and address of person who completed cause of death (Item 23a) *(Type, Print)*: Kevin M. Corrin MD 1 Bouton Dr Suite 106 Wilmington 19804

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 23 1997

32. Registrar's Signature: Julia Davidson-Randall

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

8+1VA

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17369

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: LEONARD LUBINSKY

2. Date of Death Month / Day / Year: MAY 10 1997

3. Time of Death: 7:50 P.M

4a. Facility Name *(If not institution, give street end number)*: SAINT JOSEPH MEDICAL CENTER

4b. City, Town, or Location of Death: TOWSON, MARYLAND

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 196-18-2181

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 71 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: February 27, 1926

9. Birthplace *(State or Foreign Country)*: Johnstown Pennsylvania

Usuel Residence of Decedent

10a. Stete: Pennsylvania

10b. County: York County

10c. City, Town or Location: Shrewsbury

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 29 East Forrest Road

10f. Zip Code: 17361

10g. Citizen of Whet Country?: United States of America

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Giva Yeer or Detes: July 1944 to Nov. 1945

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*

14. Race - American Indian, Black, Whita, atc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 / College (1-4or 5+):

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Laborer

16b. Kind of Business/Industry: Bethelehem Steel Manufacturing

17. Father's Neme *(First, Middle, Last)*: Walter Lubinsky

18. Mother's Neme *(First, Middle, Meiden Surneme)*: Kate Tragonich

19e. Informent's Name/Reletionship *(Type, Print)*: Irene L. Lubinsky - Wife

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 29 East Forrest Road Shrewsbury, PA 17361

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Pleca of Disposition *(Neme of cemetery, cremetory or other piece)*: Grandview Cemetery

Dete: May 14, 1997

20c. Location - City or Town, Stata: Southmont Burrough, PA

21. Signature of Funerel Service Licensee: #M00690 Howard A Carson

22. Name end Address of Facility: Francis G. Ozog Funeral Home, Inc. 710 Broad Street, Johnstown, PA 15906

Physician /Medical Examiner

23a. Part1. Enter the disaase, or complications that caused tha daath. Do not antar tha mode of dying, such as cardiac or raspiratory arrest, shock, or heart feilure. List only one ceuse on eech line.

Approximete Intervel Between Onsat and Deeth

Immediate Ceuse (Finei disaese or condition resulting in deeth)

e. CONGESTIVE HEART FAILURE

Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Lest

b. DILATED CARDIOMYOPATHY

Due to (or es e consequence of):

c. LIVER CIRRHOSIS

Due to (or as a consequence of):

d. PROSTATE CARCINOMA

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☒ Yes 2☐ No

24b. Ware autopsy findings available prior to completion of causa of deeth? 1☒ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Piece of Deeth *(Check only one)*: Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Tima of injury

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the cause(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of exemination and/or investigetion, in my opinion, deeth occurred et the time, date end piece, end dua to tha cause(s) and manner stated.

29b. Signeture end titla of certifier: [illegible] M.D.

29c. Licanse number: D28244

29d. Date signed *(Month, Dey, Year)*: MAY- 12- 1997

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print): FOWZIA TAQI, M.D. 7620 YORK ROAD TOWSON, MARYLAND 21204

State Registrar

31. Dete filed *(Month, Dey, Year)*: MAY 19 1997

32. Registrar's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 17370

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edith B. Lease

2. Date of Death Month: May Day: 11 Year: 1997

3. Time of Death: 11:00 PM

4a. Facility Name (If not institution, give street and number): Northampton Manor Nursing Center

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 216-38-1126

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): Nov. 9, 1906

9. Birthplace (State or Foraign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Insida City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 11650 Old Annapolis Road

10f. Zip Code: 21701

10g. Citizen of What Country?: American

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedant Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Giva Yaar or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own home

17. Father's Name (First, Middle, Last): Walter E. Burall

18. Mother's Name (First, Middle, Maiden Surname): Addie Utz

19a. Informant's Name/Relationship (Type, Print): Betty A. Thompson -Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11650 Old Annapolis Road, Frederick, Maryland 21701

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Pleasant Hill Cemetery

Data: 5/15/97

20c. Location - City or Town, State: Monrovia, Maryland

21. Signature of Funeral Service Licansee: Olin L. Molesworth

22. Name and Address of Facility: Olin L. Molesworth, P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872-0117

Physician /Medical Examiner

23a. Part1. Enter tha disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cerebrovascular accident — 24 hours

Due to (or as a consequenca of):
b. Atherosclerosis. — several yrs.

Saquantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequenca of):
c.

Dua to (or as a consequenca of):
d.

Part II. **Other significant conditione** contributing to death but not resulting in the underlying cause given in Part I.: Diabetes mellitus, coronary artery disease, dementia

23b. Did tobacco use contribute to the causs of death? 1☐ Yss 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No NA

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year): NA

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: A. Majeed MD

29c. License number: D 18063

29d. Date signed (Month, Day, Year): May 12, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): A. Majeed, M.D. 801 Toll House Avenue, Frederick, Maryland 21701

State Registrar

31. Date filed (Month, Day, Year): MAY 13 1997

32. Registrar's Signature: Julia Dawson Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17371

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: E. Pauline Long

2. Date of Death Month Day Year: May 9, 1997

3. Time of Death: 9:20 PM

4a. Facility Name *(If not institution, give street and number)*: 113 Perry Corner Road

4b. City, Town, or Location of Death: Grasonville

4c. County of Death: Queen Anne's

Funeral Director

5. Social Security Number: 213-01-5683

6. Sex: 1☐ M 2☐ F XX

7. Age *(In yrs. last birthday)*: 93 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Feb. 1, 1904

9. Birthplace *(State or Foreign Country)*: Md.

Usual Residence of Decedent

10a. State: Md.

10b. County: Queen Anne's

10c. City, Town or Location: Grasonville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 201 Station Lane

10f. Zip Code: 21638

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed XX 4☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No XX If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No XX Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Seamstress

16b. Kind of Business/Industry: Perfect Garment

17. Father's Name *(First, Middle, Last)*: John Franklin Seward

18. Mother's Name *(First, Middle, Maiden Surname)*: Florence Rebecca Clevenger

19a. Informant's Name/Relationship *(Type, Print)*: Sister Mrs. Mildred Dawkins

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 205 Windsor Ave., Centreville, Md. 21617

20a. Method of Disposition: 1☒ Burial XX 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other piece)*: Stevensville Cemetery

Date: May 13, 1997

20c. Location - City or Town, State: Stevensville, Md.

21. Signature of Funeral Service Licensee: Chad M. Helfenbein

22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 106 Shamrock Rd., Chester, Md. 21619

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CNS tumor — 6 mo

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D057594

29d. Date signed *(Month, Day, Year)*: 5-12-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ralph E. Libby, M.D.; 204 Medical Center Rd., Grasonville, Md. 21638

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 12 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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P.C.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items:23a part I,27,28a-f per MEO G-749 7/1/97 dh

Certificate of Death

Reg. No. 97 17372

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: PAMELA MARIE WHITTINGTON LEIGH
2. Date of Death Month Day Year: 5-29-97
3. Time of Death: 2:42p.m.
4a. Facility Name *(If not institution, give street and number)*: SACRED HEART HOSPITAL
4b. City, Town, or Location of Death: LONACONING
4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 216-74-6052
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 39 Yrs. If Under 1 Yaar: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Oct 24, 1957
9. Birthplece *(Stata or Foreign Country)*: Maryland

Usual Residenca of Decedent

10a. State: Maryland
10b. County: Garrett
10c. City, Town or Location: Ockland
10d. Insida City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 10 Stanton Lane
10f. Zip Code: 21550
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorcad
12. Was Dacadant Evar in U,S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Yaar or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Spacify:*
14. Raca - American Indian, Black, White, etc. *Specify:* White

15. Decadent's Education *(Spacify only highast grada complatad)*: Elementary/Secondary (0-12): 11 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratired)*: Property Manager
16b. Kind of Business/Industry: Real Estate

17. Father's Name *(First, Middla, Last)*: Thomas E. Whittington
18. Mother's Name *(First, Middla, Maidan Surnama)*: Janet Marie Schwalier

19a. Informant's Name/Relationship *(Type, Print)*: Janet Marie Whittington- Mother
19b. Mailing Address *(Straat and Number or Rural Routa Numbar, City or Town, Stata, Zip Coda)*: 174 Chesapeake Moble Ct, Hanover, MD 21076

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Spacify)*
20b. Place of Disposition *(Name of cematary, cramatory or other place)*: Metropolitan Crematory
Date: 6/02/97
20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service licensee: Henry L Gasch
22. Name and Address of Facility: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville MD 20781

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disaasa or condition resulting in death): e. AMITRIPTYLINE INTOXICATION

Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in daath) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consaquance of):

d.

Part II. **Other algnificent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of causa of death? 1☒ Yes 2☐ No

25. Was casa refarred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only ona)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA. Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other *(Spacify)*

27. Manner of Death: 1☐ Natural 2☐ Accident 3☒ Suicida 4☐ Homicida 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*: 5/29/97
28b. Tima of Injury: before 2:00 P M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: subject ingested pills
28e. Place of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*: at a residence
28f. Location *(Straat and Number or Rural Routa Number, City or Town, Stata)*: 14 Castle Hill Lonaconing, Maryland

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as steted. 2☒ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Theodore M. King MD
29c. License number: OCME
29d. Date signed *(Month, Day, Year)*: MAY 31, 1997

30. Neme and address of person who completes cause of death (Item 23a) (Type, Print): THEODORE M. KING 111 PENN ST. BALTIMORE MD 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JUN 02 1997
32. Registrar's Signature: Julia Davidson Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 17373

Certificate of Death Reg. No.

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Marjorie A. Lumsden
2. Dete of Deeth: Month May Dey 17 Yeer 1997
3. Time of Deeth: 3:55 P.M.
4a. Facility Neme *(If not institution, give street end number)*: 13001 Cheswood Lane
4b. City, Town, or Location of Deeth: Bowie
4c. County of Deeth: Prince George's

Funeral Director

5. Social Security Number: 217 30 0141
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 63 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Yeer)*: March 17,1934
9. Birthplece *(Stete or Foreign Country)*: Washington D.C.

Usuel Residance of Decedent

10a. Stete: Maryland
10b. County: Prince George's
10c. City, Town or Location: Bowie
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 13001 Cheswood Lane
10f. Zip Code: 20715
10g. Citizen of Whet Country?: United States
11. Maritel Stetus: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Wes Decedent Ever in U.S. Armed Forces?: 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elemantary/Secondary (0-12); College (1-4or 5+): 2
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Computer Analyst
16b. Kind of Busines/Industry: U.S. Government
17. Fether's Neme *(First, Middle, Last)*: Harold G. Heritage
18. Mother's Name *(First, Middle, Maiden Sumeme)*: Marie Pabst
19a. Informent's Neme/Relationship *(Type, Print)*: Stephen M. Lumsden Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7395 S. Robin Court Hanover Maryland 21076
20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other place)*: Lakemont Memorial Gardens — Date: 5/20/97
20c. Location - City or Town, Stete: Davidsonville Md.
21. Signeture of Funerel Service Licensee: [signature]
22. Neme end Address of Facility: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715

Physician /Medical Examiner

23a. Part I. Enter the disease, or complicetions thet caused tha daath. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

		Approximete Intervel Between Onset and Deeth
Immediate Cause (Finel diseese or condition resulting in deeth)	a. Pulmonary edema	2weeks
Dua to (or as e consequence of):	b. idiopathic cardiomxopathx	2 years
Sequentielly list conditions, if any, leeding to Immadiate cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest	c.	
Due to (or es a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Rhevmatoid arthritis; vasculitis; COPD

23b. Did tobacco uee contributa to the cauee of death?: 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Wes en eutopsy performed?: 1☐ Yes 2☒ No

24b. Ware autopsy findings eveileble prior to completion of cause of deeth?: 1☐ Yes 2☒ No

25. Wes case referred to medical exeminer?: 1☐ Yes 2☒ No

26. Plece of Deeth *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Yeer)*
28b. Time of Injury
28c. Injury et Work?: 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Phyeician:** To tha best of my knowledge, deeth occurred et the time, dete end pleca, and due to the cause(s) end menner es steted. 2☐ **Medical Examiner:** On tha basis of examinetion end/or investigation, in my opinion, daath occurred et tha time, date end place, end due to the cause(s) end mannar steted.

29b. Signature end title of certifier: [signature]
29c. License number: D29571
29d. Date signed *(Month, Dey, Yeer)*: 5/19/97

30. Neme and address of peraon who completed causa of daeth (Item 23a) (Type, Print): PAUL BEREZ, MD 1655 Crofton Blvd #101 Crofton, MD 21114

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: MAY 21 1997
32. Registrar's Signeture: [signature]

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17374

McLAUGHLIN, Carrie

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CARRIE Mc LAUGHLIN
2. Date of Death (Month, Day, Year): MAY 19, 1997
3. Time of Death: 11:30AM
4a. Facility Name (If not institution, give street and number): PRINCE GEORGES HOSPITAL
4b. City, Town, or Location of Death: CHEVERLY
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 579-28-5005
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAY 18, 1918
9. Birthplace (State or Foreign Country): GEORGIA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: N/A
10b. County: N/A
10c. City, Town or Location: WASHINGTON, D.C.
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 110 GALLITON ST. N.W. APT. 103
10f. Zip Code: 20011
10g. Citizen of What Country?: UNITED STATES AMERICA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Bieck, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th GRADE; College (1-4or 5+):
18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): FOOD SERVICE WORKER
16b. Kind of Business/Industry: PRIVATE

17. Father's Name (First, Middle, Last): BOYKIN NORMAN
18. Mother's Name (First, Middle, Maiden Surname): MATTIE IVY NORMAN

19a. Informant's Name/Relationship (Type, Print): MARGARET A. WINGFIELD
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17604 CASHELL RD., ROCKVILLE, MD. 20853

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MARYLAND NATIONAL CEM.
Date: 5/23/97
20c. Location - City or Town, State: LAUREL, MD.

21. Signeture of Funeral Service Licansee: Delna J. Jenkins
22. Name end Address of Facility: JOHNSON & JENKINS INC. 716 KENNEDY ST. N.W. W.D.C. 20011

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line.

Approximate interval Between Onset and Deeth

Immediete Cause (Finel disease or condition resulting in death)
a. ANOXIC ENCEPHALOPATHY >2-wks

Due to (or es a consequenca of):

Sequentially fist conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as e consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
RENAL FAILURE; Respiratory failure,
CHF; S/P Thyroidectomy

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Date of injury (Month, Day Year)
28b. Time of injury M
28c. injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier: MD
29c. License number: D-34525
29d. Dete signed (Month, Day, Year): 05-20-97

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print): S.J. Rao, MD; 4000-Mitchellville Road; #220; Bowie-MD-20716.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

(4)

State Registrar

31. Dete filed (Month, Dey, Year): MAY 23 1997
32. Registrar's Signature: Judi Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17375

LATHAM, HELEN MARIA

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last): Helen Marie Latham	2. Date of Death: Month MAY, Day 12, Year 1997	3. Time of Death: 7:09p.m.	
4a. Facility Name (If not institution, give street and number): St. Mary's Hospital	4b. City, Town, or Location of Death: Leonardtown	4c. County of Death: St. Mary's	
5. Social Security Number: 579-10-5004	6. Sex: 1☐ M 2☒ F (X)	7. Age (In yrs. last birthday): 81 Yrs.	If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): Oct.14,1915	9. Birthplace (State or Foreign Country): Maryland		
Usual Residence of Decedent			
10a. State: MD	10b. County: St. Mary's	10c. City, Town or Location: Helen	10d. Insida City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 39100 Chaptico Road	10f. Zip Code: 20635	10g. Citizen of What Country?: USA	
11. Marital Status: 1☐ Naver Married 2☐ Married 3☒ Widowed 4☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxicen, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:	14. Race - Amaricen Indian, Black, White, atc. Specify: White
15. Dacedent's Educetion (Specify only highest grade completed): Elementary/Secondary (0-12): 8th Grade; College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired): Homemaker	16b. Kind of Business/Industry: Own Home	
17. Father's Name (First, Middle, Last): James Francis Guy	18. Mothar's Name (First, Middle, Maiden Surname): Florence Latham		
19a. Informant's Name/Relationship (Type, Print): Richard J. Latham	19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code): 8624 Madley Coury, Springfield, VA 22152		
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	20b. Place of Disposition (Nama of cemetery, crematory or other place): Gate of Heaven Cemetery	Date: 5/16/97	20c. Location - City or Town, State: Silver Spring, MD
21. Signature of Funeral Service Licensaa: Michael K. Gardiner	22. Name and Address of Facility: Mattingley-Gardiner Funeral Home, P.A. 41590 Fenwick St., P.O.Box 270, Leonardtown, MD 20650		

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter tha disease, or complications that caused the daath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one causa on aach lina.

Approximata Interval Between Onset and Death

Immediata Cause (Finai disaasa or condition resulting in daath)
a. Pseudomonas Pneumonia — 2wks

Due to (or as a consequenca of):
b.

Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consaquence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I: COPD, CHF (congestive Heart Failure) Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Mannar of Death: 1☐ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28a. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledga, death occurred at tha tima, data and place, and due to tha cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and piace, and due to the cause(s) and manner stated.

29b. Signature and title of certifier | 29c. License number: D19917 | 29d. Date signed (Month, Day, Year): 5/15/97

30. Name and address of person who completed cause of death (item 23a) (Type, Print): Jamie C. Boyd, MD St. Mary's Medical Association, LLC, 2050 Wildewood Center, California, MD 20619

State Registrar

31. Date filed (Month, Day, Year): MAY 16 1997

32. Registrar's Signatura: Julie Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17376

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Rowena Gertrude Lyon

2. Data of Death Month Day Yaar: May 18, 1997

3. Tima of Death: 12:45 P.M.

4a. Facility Nama *(If not institution, give street and number)*: Westminster Nursing Home

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 213 34 7653

6. Sex: 1☐ M 2☒ F

7. Aga *(In yrs. last birthday)*: 84 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Yaar)*: Jan. 23, 1913

9. Birthplace *(Stata or Foreign Country)*: Arkansas

Usual Residence of Decedant

10a. State: Md.

10b. County: Carroll

10c. City, Town or Location: Westminster

10d. Inaida City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1234 Old Washington Road

10f. Zip Coda: 21157

10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1☐ Nevar Marriad 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:

13. Was Dacedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxicen, Puarto Ricen, atc.): 1☐ Yas 2☒ No *Specify:*

14. Race - American Indian, Black, White, atc. *Specify*: White

15. Decedent's Educetion *(Specify only highast grada compiatad)*: Elementary/Secondary (0-12): 11 — Collega (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work done during most of working life. DO NOT usa retired)*: Homemaker

16b. Kind of Business/Industry: Home

17. Father's Name *(First, Middle, Last)*: Robert Wherry

18. Mothar's Nama *(First, Middla, Maidan Sumama)*: Julia Atkins

19a. Informant's Name/Relationship *(Type, Print)*: Louis Lyon

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 8251 Savage Gulford Rd. Savage, Md. 20763

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Spacify)*

20b. Placa of Disposition *(Nama of cematary, cramatory or othar placa)*: Lake View Mem. Park — Date: 5/21/97

20c. Location - City or Town, Stata: Sykesville, Md.

21. Signature of Funeral Service Licensee: ▶ Harry W. Haight

22. Nama and Address of Facility: Haight Funeral Home, Sykesville, Md. 21784 P.O.Box 195

Physician /Medical Examiner

23a. Part1. Enter tha diseasa, or complications that caused tha death. Do not antar tha moda ot dying, such as cardiac or raspiratory arrest, shock, or heart failura. List only one cause on aach lina.

Approximata Interval Batwaen Onsat and Death

Immadiata Causa (Final diseasa or condition rasulting in death): e. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Dua to (or as a consequance ot):

Sequantially list conditions, if any, leading to immadiata ceusa. Enter Underlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last:

b.

Due to (or as a consaquance ot):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying causa givan in Part I.: DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Wara autopsy findings availabla prior to completion ot causa ot death? 1☐ Yas 2☐ No

25. Was cesa refarred to medicel examinar? 1☐ Yas 2☒ No

26. Placa of Death *(Check only one)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA — Othar: 4☒ Nursing Home 5☐ Residanca 6☐ Othar *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicida 5☐ Panding Investigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Placa of Injury - At home, farm, straat, factory, office building, atc. *(Spacify)*

28f. Location *(Straat and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Phyaician:** To tha bast of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and manner as statad. 2☐ **Medical Examiner:** On tha basis ot examinetion and/or invastigetion, in my opinion, death occurrad at the time, dete and place, and due to tha cause(s) and mannar stated.

29b. Signature and title of certifiar: ▶ Howard G. Lanham MD

29c. Licensa number: D17040

29d. Date signed *(Month, Day, Year)*: 05-19-97

30. Nama and address ot person who completed causa ot daath (Item 23a) (Type, Print): Howard G. Lanham, M.D. 215 Washington Heights Med'l Ctr, Westminster, MD 21157

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 20 1997

32. Registrar's Signature: Julia Dispelcer Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

RKD
97-2873-043

YOSEF
LIPSKAR

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items:23a part I,27,28a-f per MEO 6/17/97 dh

Certificate of Death

Reg. No. 97 17377

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): YOSEF MOSHE LIPSKAR

2. Date of Death — Month: MAY; Day: 25; Year: 1997

3. Time of Death: 10:30A.M.

4a. Facility Name (If not institution, give street and number): ROXBURY CORRECTIONAL INSTITUTION

4b. City, Town, or Location of Death: HAGERSTOWN

4c. County of Death: WASHINGTON

Funeral Director

5. Social Security Number: 494-80-2897

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 36 Yrs.

If Under 1 Year — Months: ; Days:

If Under 24 Hrs. — Hours: ; Min.:

8. Date of Birth (Month, Day, Year): April 3, 1961

9. Birthplace (State or Foreign Country): Tel Aviv, Israel

Usual Residence of Decedent

10a. State: MD

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 18701 Roxbury Road

10f. Zip Code: 21740

10g. Citizen of What Country?: USA

11. Maritel Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorcad

12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 4

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Drafter

16b. Kind of Business/Industry: Self Employed

17. Father's Name (First, Middle, Last): Jack N. Lipskar

18. Mother's Name (First, Middle, Maiden Surname): Darlene Dien

19a. Informant's Name/Relationship (Type, Print): Lorraine K. Ortiz, Fiancee

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 921-F Lanvale Street, Hagerstown, Maryland 21740

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Placa of Disposition (Name of cemetery, crematory or other placa): Smithsburg Crematory

Date: May 29

20c. Location - City or Town, State: Smithsburg, Maryland

21. Signature of Funeral Service Licensee: Kelly A. Younker

22. Name end Address of Facility: Douglas A. Fiery Funeral Home
1331 Eastern Blvd. N., Hagerstown, Maryland 21742

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Intervei Between Onset end Deeth

Immediate Cause (Final disease or condition resulting in death):
a. ACUTE NARCOTIC INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequenca of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings availeble prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one)
Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [X] Residenca 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [X] Could not be determined

28a. Date of Injury (Month, Day Year): found 5/25/97

28b. Time of Injury: found at 8:00 A M

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how Injury occurred: unknown

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify): found in jail cell

28f. Location (Street and Number or Rural Route Number, City or Town, State): Roxbury Correctional Institution Hagerstown, Maryland

29a. Certifier (Check only one)
1 [ ] **Certifying Phyaician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dennis J. Chute MD

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): MAY 26,1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis J. Chute, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JUN 03 1997

32. Registrar's Signature: Julie Thacker Rachel

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Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17378

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lenora Irene LOHR

2. Date of Death: Month MAY Day 24 Year 1997

3. Time of Death: 05:00 AM

4a. Facility Name (If not institution, give street and number): Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 214-09-3639

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 26, 1912

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 511 Frederick Street

10f. Zip Code: 21740

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 0-8 | College (1-4 or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): knitter

16b. Kind of Business/Industry: hosiery

17. Father's Name (First, Middle, Last): Chester Lohr

18. Mother's Name (First, Middle, Maiden Surname): Florence Estella Wolf

19a. Informant's Name/Relationship (Type, Print): Mrs. Dorothy Dinkle/sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 909 Frederick Street, Hagerstown, Maryland 21740

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Rose Hill Cemetery

Date: May 27, 1997

20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Scott Minnich

22. Name and Address of Facility: Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Cerebrovascular accident — minutes
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [illegible], MD

29c. License number: D32518

29d. Date signed (Month, Day, Year): 5.24.97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Dr Guedenet 100 Eceting Ln. Keedysville MD 21756

State Registrar

31. Date filed (Month, Day, Year): MAY 27 1997

32. Registrar's Signature: [illegible]

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

LENORA IRENE LOHR

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17379

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Clarence Daniel Longanecker

2. Date of Death Month: May Day: 22 Year: 1997

3. Time of Death: 9 15 pm

4a. Facility Name *(If not institution, give street and number)*: Homewood Retirement Center

4b. City, Town, or Location of Death: Williamsport

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 214-09-3642

8. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 96 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 1, 1901

9. Birthplace *(State or Foreign Country)*: Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 307 N. Locust Street

10f. Zip Code: 21740

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: machinist

16b. Kind of Business/Industry: aircraft manufacturing

17. Father's Name *(First, Middle, Last)*: Elmer Gaines Longanecker

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Eleanor Summers

19a. Informant's Name/Relationship *(Type, Print)*: Catherine Longanecker

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 307 N. Locust Street Hagerstown, Maryland 21740

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory, or other place)*: Rose Hill Cemetery

Date: 5/27/97

20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Gerald N. Minnich

22. Name and Address of Facility: Gerald N. Minnich Funeral Home, 305 N. Potomac Street, Hagerstown, Maryland 21740

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia — Approximate Interval: 1 week

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

metastatic prostatic carcinoma

Dementia - multi infarct

Arteriosclerosis

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D26806

29d. Date signed *(Month, Day, Year)*: 5/23/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): [illegible] 747 Northern Ave Hagerstown MD 21742

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 27 1997

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

5-22-97 915p

Clarence Longanecker

97-2838-001
ML
ARLYN E.LOGAN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17380

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ARLYN EDWARD LOGAN, I

2. Date of Death (Month, Day, Year): MAY 22 1997

3. Time of Death: 12:00 PM

4a. Facility Name (If not Institution, give street and number): 210 AVIRETT AVENUE

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 218-50-0342

6. Sex: 1☐ M 2☐ F (X)

7. Age (In yrs. last birthday): 47 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct 14, 1949

9. Birthplace (State or Foreign Country): MD

Usual Residance of Decedent

10a. State: MD

10b. County: Allegany

10c. City, Town or Location: Cumberland

10d. Inside City Limits: 1(X) Yes 2☐ No

10e. Street end Number: 210 Avirett Avenue

10f. Zip Code: 21502

10g. Citizen of What Country?: USA

11. Maritel Status: 1☐ Never Married 2(X) Married 3☐ Widowed 4☐ Divorced

12. Was Decadent Ever in U.S. Armed Forces? 1(X) Yes 2☐ No
If Yes, Give Year or Dates: Vietnam

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.)
1☐ Yes 2(X) No Specify:

14. Race - Americen Indian, Bleck, White, etc.
Specify: white

15. Decedent's Educetion (Specify only highest grade completed)
Elemantary/Secondary (0-12): 12
College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Construction Worker

16b. Kind of Business/Industry: Local 616

17. Father's Name (First, Middle, Last): Raymond Edward Logan

18. Mother's Name (First, Middle, Maiden Surname): Laura Mae (Childress)

19a. Informant's Name/Relationship (Type, Print): Laura M. Logan--mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 710 Shade's Lane; Cumberland, MD 21502

20a. Method of Disposition: 1(X) Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cramatory or other place): Rocky Gap Veterans Cem

Date: 05/27

20c. Location - City or Town, State: Flintstone, MD

21. Signature of Funeral Service Licensee: Nicholas J Scarpelli

22. Name and Address of Facility: Scarpelli Funeral Home
Cumberland, MD 21502

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Atherosclerotic Cardiovascular disease

Dua to (or as a consequanca of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated avants resulting in deeth) Lest
b.

Due to (or es a consequence of):
c.

Due to (or as a consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceusa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3(X) Probably 4☐ Unknown

24a. Was an autopsy performed? 1(X) Yes 2☐ No

24b. Ware eutopsy findings available prior to complation of ceuse of death? 1(X) Yes 2☐ No

25. Was case referrad to medical examiner? 1(X) Yes 2☐ No

26. Place of Death (Check only ona)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Homa 5(X) Residence 6☐ Other (Specify)

27. Manner of Death: 1(X) Natural 2☐ Accident 3☐ Sulcide 4☐ Homlcide 5☐ Pending investigation 8☐ Could not be detarmined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, straat, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifiar (Check only one): 1☐ **Certifying Phyatcian**: To the best of my knowladga, daath occurred at the tima, data and place, and dua to tha cause(s) and manner as stated.
2(X) **Medtcal Examinar**: On the basis of axamination and/or tnvestigation, in my opinion, daath occurred at tha tima, date and placa, and dua to tha causa(s) and mannar stated.

29b. Signature and ~~title of certifier~~: [signature]

29c. Licanse number: O.C.M.E.

29d. Date signed (Month, Day, Year): MAY 23,1997

30. Nama and address of person who complated causa of daath (Item 23a) (Type, Print)
David Fowler, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): MAY 27 1997

32. Registrar's Signature: John Davison Randall

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Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17381

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: William Franklin Leftwich
2. Date of Death Month Day Year: May 22, 1997
3. Time of Death: 8:03 am
4a. Facility Name *(If not institution, give street and number)*: Pleasant Living Convalescent Center
4b. City, Town, or Location of Death: Edgewater
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 213 20 3706
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 70 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sept. 6, 1926
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Lothian
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 50 Lyons Creek Mobile Home Estates
10f. Zip Code: 20711
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No — If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Cook
16b. Kind of Business/Industry: Restaurant

17. Father's Name *(First, Middle, Last)*: John William Leftwich
18. Mother's Name *(First, Middle, Maiden Surname)*: Emily Melton

19a. Informant's Name/Relationship *(Type, Print)*: Esther I. Leftwich/wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: same as 10 above

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Maryland Veterans Cem.
Date: 5-28-97
20c. Location - City or Town, State: Cheltenham, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Rausch Funeral Home, Owings, MD 20736

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Acute Cardiac Insufficiency — 2 yrs.
Due to (or as a consequence of):
b. Arteriosclerotic Heart Disease
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] Deputy
29c. License number: D06054
29d. Date signed *(Month, Day, Year)*: 5/23/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William P. Jones, MD 6131 Shady Side Rd 20764

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 27 1997
32. Registrar's Signature: [signature] Julia Davidson Rudolph

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

4

1 VA

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17382

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: STEPHEN PHILIP LAIKO
2. Date of Death Month: MAY Day: 21 Year: 1997
3. Time of Death: 2:05 AM
4a. Facility Name *(If not institution, give street and number)*: NATIONAL NAVAL MEDICAL CENTER
4b. City, Town, or Location of Death: BETHESDA
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 016-14-9981
6. Sex: 1☐M 2☐F XX
7. Age *(In yrs. last birthday)*: 74 Yrs.
If Under 1 Yaar: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: Oct 5, 1922
9. Birthplace *(State or Foreign Country)*: Mass

To Be Completed by Funeral Director

Usual Residence of Dacedent

10a. Stata: Maryland
10b. County: Prince George's
10c. City, Town or Location: Fort Washington
10d. Inside City Limits: 1☐Yes 2☒No XX
10e. Street end Number: 9611 Caltor Lane
10f. Zip Code: 20744
10g. Citizan of What Country?: United States

11. Marital Status: 1☐Never Married XX Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes XX 2☐No
If Yas, Giva Yaer or Detas: 1943 1965
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.): 1☐Yes 2☐No X *Specify:*
14. Race - American Indian, Bieck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade compiated)*: Elementary/Secondery (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work dona during most of working life. DO NOT use retired)*: Administrative Support
16b. Kind of Business/Industry: US Air Force

17. Fether's Neme *(First, Middle, Last)*: Philip Laiko
18. Mother's Neme *(First, Middle, Meiden Surname)*: Tillie Wasik

19a. Informant's Neme/Reletionship *(Type, Print)*: Jennie B. Laiko
19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 9611 Calton Lane, Fort Washington , Md 20744

20a. Method of Disposition: 1☒Burial 2☐Cremetion 3☐Removal from Stete 4☐Donetion 5☐Othar *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or othar piece)*: Maryland Veterans Cemetery
Date: May 28 1997
20c. Location - City or Town, State: Cheltenham, Maryland

21. Signature of Funerel Sarvice Licensee: Reginald [illegible]
22. Nama and Address of Facility: Lee Funeral Home,Inc 6633 Old Alexandria Ferry Road, Clinton,Maryland 20735

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiretory arrast, shock, or heart failure. List only one ceuse on eech line. — Approximata Interval Between Onsat and Death

Immediate Cause (Finel disaesa or condition resulting in death): e. MASSIVE MYOCARDIAL INFARCTION
Due to (or es a consequence of):

Sequentielly list conditions, if any, leading to immedieta cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Last:
b.
Due to (or as e consequence of):
c.
Dua to (or es a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Wes an autopsy performed? 1☐Yes 2☒No X
24b. Were autopsy findings availeble prior to completion of cause of death? 1☐Yes 2☐No

25. Wes case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death *(Check only one)*: Hospitel: 1☒Inpatient 2☐ER/Outpetient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Menner of Death: 1☒Naturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigetion 6☐Could not be determined
28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describa how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, atc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the bast of my knowledge, deeth occurred at the time, dete end pleca, end dua to the ceuse(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) and mennar stated.

29b. Signature end title of certifier: Edward Omron MD
29c. License number: 4301069097 (MI)
29d. Data signed *(Month, Day, Year)*: 21 May 97

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print): EDWARD M. OMRON, LT, MC, USNR
NATIONAL NAVAL MEDICAL CENTER
BETHESDA MD 20889-5600

State Registrar

31. Deta filed *(Month, Day, Year)*: MAY 27 1997
32. Registrer's Signetura: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RKD
97-2846-017
DOLORES
LOVE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17383

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: DOLORES BEATRICE LOVE

2. Dete of Daeth: Month MAY; Day 23; Yeer 1997

3. Time of Deeth: 8:41A.M.

4e. Feeility Neme *(If not institution, give street end number)*: PHYSICIANS MEMORIAL HOSPITAL

4b. City, Town, or Location of Death: LAPLATA

4c. County of Deeth: CHARLES COUNTY

Funeral Director

5. Social Security Number: 432-30-9579

6. Sex: 1☐ M 2☐ F X

7. Age *(In yrs. lest birthday)*: 76 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Yaar)*: DEC.13,1920

9. Birthplece *(Stete or Foreign Country)*: ARKANSAS

Usuel Residence of Decedent

10a. Stata: MARYLAND

10b. County: CHARLES

10c. City, Town or Location: NEWBURG

10d. Inside City Limits: 1☐ Yes 2☐ No X

10e. Street end Number: 11645 CUCKOLD CREEK ROAD

10f. Zip Code: 20664

10g. Citizen of Whet Country?: U.S.A.

11. Maritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed X 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates: WWII 43-44

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☐ No X *Specify:*

14. Race - American Indien, Bleck, White, etc. *Specify:* WHITE

15. Decedent's Educetion *(Specify only highest grede completed)*: Elemantery/Secondary (0-12): 12; College (1-4or 5+):

16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: STORE OWNER

16b. Kind of Business/Industry: GENERAL MERC.STORE

17. Fether's Neme *(First, Middle, Last)*: HENRY BARNEY LIPSMEYER

18. Mother's Nama *(First, Middle, Maiden Surnema)*: MARIE ESTELLE MARTIN

19e. Informant's Name/Reletionship *(Type, Print)*: LAWRENCE E. HAYDEN,JR.

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 14506 SAND PABLO DR.N. JACKSONVILLE,FL.32224

20e. Method of Disposition: 1☒ Burial X 2☐ Cremation 3☐ Removal from Stete 4☐ Donetion 5☐ Othar *(Specify)*

20b. Piece of Disposition *(Neme of cemetary, cremetory or other pleca)*: ARLINGTON NAT.CEMETERY

Date: 5-29-97

20c. Location - City or Town, State: ARLINGTON,VA.

21. Signature of Funeral Service Licensee: Michael D. Raymond

22. Name and Address of Feciility: RAYMOND FUNERAL SERVICE
LA PLATA,MARYLAND 20646

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiretory arrest, shock, or heert failure. List only one cause on eech line.

Approximete Intervel Between Onset end Death

Immediete Cause (Finel diseese or condition resulting in daath)
a. Multiple Injuries

Due to (or es a consequence of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initietad events resulting in deeth) Last
b.

Due to (or es e consequence of):
c.

Due to (or es e consequence of):
d.

Part II. **Other elgnificent conditione** contributing to death but not rasulting in the underlying ceuse givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yee 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings evelleble prior to completion of cause of deeth? 1☒ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☒ Yes 2☐ No

26. Plece of Daath *(Chack only one)*: Hospitel: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Data of Injury *(Month, Day Yaar)*: 5-23-97

28b. Time of Injury: 0755 M

28c. Injury at Work? 1☐ Yas 2☒ No

28d. Describe how injury occurred: Automobile Accident

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: Street

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: Route 234 and 301 Charles County, Maryland

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☐ **Certifying Phyeician:** To tha best of my knowledga, daath occurred et tha tima, data and place, end dua to the causa(s) and mannar as stated. 2☒ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurred et tha tima, date end place, and dua to tha cause(s) end manner stated.

29b. Signature end title of certifier: Stephen S. Radentz, MD

29c. License number: O.C.M.E.

29d. Date signed *(Month, Dey, Year)*: MAY 24,1997

30. Nama and eddress of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz, MD 111 Penn Street, Baltimore, Maryland 21201

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Data filed *(Month, Day, Year)*: MAY 27 1997

32. Registrer's Signeture: Julie Davidson Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17384

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Patricia Marie McCarthy
2. Date of Death Month Day Year: May 15, 1997
3. Time of Death: 1:00 PM
4a. Facility Name *(If not institution, give street and number)*: 5 Turnmore Court
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 554-42-0552
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 63 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Aug.19,1933
9. Birthplace *(State or Foreign Country)*: California

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5 Turnmore Court
10f. Zip Code: 20906
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Travel Agent
16b. Kind of Business/Industry: Sales

17. Father's Name *(First, Middle, Last)*: George Coughlin
18. Mother's Name *(First, Middle, Maiden Surname)*: Buelah Pauline French

19a. Informant's Name/Relationship *(Type, Print)*: L. Dennis McCarthy
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5 Turnmore Court Silver Spring, Maryland 20906

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory
Date: 5/21/97
20c. Location - City or Town, State: Alexandria,Virginia

21. Signature of Funeral Service Licensee: Steven D Strand
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd.,W.,Sil.Spr.,Maryland 20901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Acute Myocardial Infarction — 5 Mins.
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: John Tauber MD
29c. License number: D08546
29d. Date signed *(Month, Day, Year)*: May 15, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John F. Tauber, M.S. 8218 Wisconsin Avenue #318 Bethesda,Maryland 20814-3107

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 19 1997
32. Registrar's Signature: Lisa Davidson-Randall

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

12

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17385

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Georgia METRAKOS

2. Date of Death Month 5 Day 20 Year 97

3. Time of Death 11:10

4a. Facility Name (If not institution, give street and number): Mariner Health Care

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 213-50-6064

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 28, 1914

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Chevy Chase

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3320 Shepherd Street

10f. Zip Code: 20815

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Theophanes Metrakos

18. Mother's Name (First, Middle, Maiden Surname): Doliteme Stangos

19a. Informant's Name/Relationship (Type, Print): Terpsia Lampros / Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3320 Shepherd Street, Chevy Chase, Maryland 20815

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Fort Lincoln Cemetery

Date: 5/22/97

20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service License: [signature]

22. Name and Address of Facility: Hines-Rinaldi Funeral Home
11800 New Hampshire Avenue
Silver Spring, Maryland 20904

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis — days

Due to (or as a consequence of):

b. Breast Cancer — weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D33357

29d. Date signed (Month, Day, Year): 5/20/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Lee Jonathan Mushen MD 5530 Wisconsin Ave Chevy Chase MD 20815

State Registrar

31. Date filed (Month, Day, Year): MAY 23 1997

32. Registrar's Signature: Gina Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17386

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CLARA K. MILLER
2. Date of Death Month/Day/Year: MAY 19, 1997
3. Time of Death: 1:40 AM
4a. Facility Name (If not institution, give street and number): Washington Adventist Hospital
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 082-12-2845
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 73 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 16, 1923
9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince Georges
10c. City, Town or Location: Hyattsville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 6205 Sargent Road
10f. Zip Code: 20782
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): John Kerr
18. Mother's Name (First, Middle, Maiden Surname): Julia Haffney

19a. Informant's Name/Relationship (Type, Print): Wallace E. Miller, Sr./Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6205 Sargent Road, Hyattsville, Maryland 20782

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): George Washington Cem.
Date: 5/21/97
20c. Location - City or Town, State: Adelphi, Maryland

21. Signature of Funeral Service Licensee: Thomas Guyon
22. Name and Address of Facility: Hines-Rinaldi Funeral Home, 11800 New Hampshire Avenue, Silver Spring, Maryland 20904

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
e. Acute Respiratory failure

Due to (or as a consequence of):
b. Multiple myeloma, Light chain disease — 4 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

Due to (or as a consequence of):
c. Chronic obstructive Pulmonary Disease

Due to (or as a consequence of):
d. Renal insufficiency

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Sajeev Anand, MD
29c. License number: D-33482
29d. Date signed (Month, Day, Year): May 19th, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Sajeev Anand, M.D. 7343-A Hanover Parkway, Greenbelt, Md. 20770.

State Registrar

31. Date filed (Month, Day, Year): MAY 23 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17387

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lois Self Wooding Mitchell
2. Data of Daath — Month: May Day: 14, Yaer: 1997
3. Tima of Death: 9:30 AM
4a. Facility Nama (If not institution, giva street and number): 5117 Westpath Way
4b. City, Town, or Location of Deeth: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 557-34-9217
6. Sex: 1☐ M 2☒ F
7. Aga (In yrs. last birthday): 85 Yrs. — If Under 1 Yaer: Months / Deys — If Undar 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): Apr. 20, 1912
9. Birthplaca (Stata or Foreign Country): Virginia

Usual Residance of Dacedent

10a. Stata: MD
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1☒ Yas 2☐ No
10e. Street and Number: 5117 Westpath Way
10f. Zip Code: 20816
10g. Citizan of What Country?: U. S. A.

11. Marital Status: 1☐ Navar Married 2☐ Marriad 3☐ Widowed 4☒ Divorced
12. Was Dacadant Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No — If Yes, Give Yaar or Datas:
13. Wes Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1☐ Yes 2☒ No Specify:
14. Raca - American Indian, Black, White, atc. Specify: White

15. Decedant's Education (Specify only highest greda compliated): Elamantary/Secondary (0-12): Colliga (1-4or 5+): 4
16a. Decedent's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa ratired): Registered Nurse & Real Estate Agent
16b. Kind of Businass/Industry: Nursing & Real Estate

17. Fathar's Nama (First, Middla, Last): Boyd W. Self
18. Mothar's Nama (First, Middle, Maidan Surnama): Olive Hudson

19a. Informant's Name/Ralationship (Type, Print): Claire Luckey - Sister
19b. Mailing Addrass (Streat and Number or Rural Route Number, City or Town, Stata, Zip Code): 3653 Upton St. N.W. Washington, D. C. 20008

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)
20b. Place of Disposition (Nama of camatary, crematory or othar placa): Fort Lincoln Cemetery
Date: 5/19/97
20c. Location - City or Town, Steta: Brentwood, Maryland

21. Signature of Funeral Sarvica Licensee: Joseph Gawler's Sons, Inc.
22. Nama and Addrass of Facility: 5130 Wisconsin Ave.,NW Washington,D.C. 20016

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

CP

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused tha daath. Do not antar tha mode of dying, such as cardiac or respiratory arrast, shock, or head failure. List only ona causa on aach lina.

Approximate Intarval Batween Onsat and Death

Immadiata Causa (Final disaasa or condition resulting in daath)
a. Chronic Obstructive Lung Disease — Years

Dua to (or as a consaquanca of):
b. Deep venous Thrombosis — 6 Months

Sequantially list conditions, if any, laading to immadiata cause. Entar Undarlying Causa (Disaasa or injury that initiated avants resulting in daath) Last
Dua to (or as a consequance of):
c. Riedels Struma — Years

Due to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha undarlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Wara autopsy findings availabla prior to completion of causa of daath? 1☐ Yas 2☐ No

25. Was casa rafarrad to medical examinar? 1☐ Yas 2☒ No

26. Placa of Death (Check only ona): Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Homa 5☒ Rasidance 6☐ Othar (Specify)

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicida 5☐ Panding Investigation 6☐ Could not be datarmined

28a. Data of Injury (Month, Day Year)
28b. Tima of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Spacify)
28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifiar (Check only one): 1☒ **Certifying Phyaician:** To tha best of my knowledga, daath occurred at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and placa, and dua to tha causa(s) and mannar stated.

29b. Signature and titla of certifiar: M. R. Lawrenz
29c. Licansa number: D18764
29d. Data signed (Month, Day, Year): 5/16/97

30. Nama and addrass of parson who compliated causa of daath (Item 23a) (Type, Print): David R. Lawrenz, M.D. 1145 19th St.,NW #600 Washington,D.C. 20036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12

State Registrar

31. Data filad (Month, Day, Year): MAY 21 1997
32. Registrar's Signatura: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17388

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Erma B. Moser
2. Date of Death (Month, Day, Year): May 20, 1997
3. Time of Death: 9:48 PM
4a. Facility Name (If not institution, give street and number): Wilson Health Care Center
4b. City, Town, or Location of Death: Gaithersburg
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 147-32-0920
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 18, 1905
9. Birthplace (State or Foreign Country): Canada

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Gaithersburg
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 301 Russell Avenue
10f. Zip Code: 20877
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Samuel Brown
18. Mother's Name (First, Middle, Maiden Surname): Florina Siebert

19a. Informant's Name/Relationship (Type, Print): Miriam M. Flaherty/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5813 Melvern Drive, Bethesda, Maryland 20817

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc. | Date: May 22, 1997
20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: Robert A. Pumphrey M00198
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home / Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. End Stage Chronic Obstructive Pulmonary Disease	years
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D33357
29d. Date signed (Month, Day, Year): 5/21/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Lee Jonathan Musher MD 5530 Wisconsin Ave Chevy Chase MD 20815

State Registrar

31. Date filed (Month, Day, Year): MAY 23 1997
32. Registrar's Signature:

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17389

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MELVIN MATTHEWS
2. Date of Death Month / Day / Year: MAY 23 1997
3. Time of Death: 12:05 pm
4a. Facility Name *(If not institution, give street and number)*: MARINERS NURSING HOME
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 216-14-5918
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 78 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: DEC. 26 1918
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: ANNAPOLIS
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 203 CENTER STREET APT. E
10f. Zip Code: 21401
10g. Citizen of What Country?: US

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces?: 1☒ Yes 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11th — College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: PAINTER
16b. Kind of Business/Industry: A.A. CO. PUBLIC SCHOOLS

17. Father's Name *(First, Middle, Last)*: WILLIAM MATTHEWS
18. Mother's Name *(First, Middle, Maiden Surname)*: ISABELL JOHNSON

19a. Informant's Name/Relationship *(Type, Print)*: HENRY GIBBS (NEPHEW)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 45 COLLEGE CREEK TERRACE ANNAPOLIS, MD. 21401

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MARYLAND VETERAN CEMETERY — Date: 5/29/97
20c. Location - City or Town, State: CROWNSVILLE, MD.

21. Signature of Funeral Service Licensee: ▶ Harry D. Reese
22. Name and Address of Facility: WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	CEREBROVASCULAR ACCIDENT	2 YEARS
Due to (or as a consequence of): b.	CORONARY ARTERY DISEASE	2 YEARS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	DUODENAL ULCER	1 YEAR
Due to (or as a consequence of): d.	CA PROSTATE	3 YEARS

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?: 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?: 1☐ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death?: 1☐ Yes 2☐ No

25. Was case referred to medical examiner?: 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury: M
28c. Injury at Work?: 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ A Matthews
29c. License number: D23530
29d. Date signed *(Month, Day, Year)*: 5-23-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ARTHUR K CHATTERJEE, 3927 ANNAPOLIS MD 21227

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 29 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17390

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: George Joseph Meisel

2. Date of Death Month: May Day: 21 Year: 1997

3. Time of Death: 6AM

4a. Facility Name *(If not Institution, give street and number)*: Anne Arundel Medical Center

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 215-10-9664

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct 25 1914

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: [XX] Yes 2 [ ] No

10e. Street and Number: 9 Tyler Court

10f. Zip Code: 21403

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? [XX] Yes 2 [ ] No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Furniture Sales

16b. Kind of Business/Industry: Retail

17. Father's Name *(First, Middle, Last)*: George T. Meisel

18. Mother's Name *(First, Middle, Maiden Surname)*: Florence Bereis

19a. Informant's Name/Relationship *(Type, Print)*: Florence A. Gryer (Daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1005 St. Margarets Dr. Annapolis, Maryland 21401

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Meadowridge Memorial Park

Date: 5/23/97

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Donald L. Lyf

22. Name and Address of Facility: John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD21401

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Acute Myocardial Infarction — Immediate

Due to (or as a consequence of):

b. Coronary Artery Disease — Yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Generalized atherosclerosis — Yrs

Due to (or as a consequence of):

d. NIDDM — Yrs

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

1. Amputation @ leg

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [XX] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [XX] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Joseph M. Friend

29c. License number: D17965

29d. Date signed *(Month, Day, Year)*: 5/21/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph M. Friend 205 Ridgely Ave Annapolis, Md. 21401

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 22 1997

32. Registrar's Signature: Julia Davidson-Randall

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17391

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: REGINA GRIBSCHAW METZ
2. Date of Death Month / Dey / Yeer: 5 / 23 / 97
3. Time of Death: 11:40pm
4a. Facility Name *(If not institution, give street and number)*: IVY HALL
4b. City, Town, or Location of Death: MIDDLE RIVER
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 206-05-9296
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthdey)*: 83 Yrs. — If Under 1 Yeer: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Yeer)*: 04-26-1914
9. Birthpiece *(Stete or Foreign Country)*: PENNSYLVANIA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: BALTIMORE
10c. City, Town or Location: MIDDLE RIVER
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1300 WINDLASS DRIVE
10f. Zip Code: 21220
10g. Citizen of Whet Country?: U.S.A.

11. Merital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Rece - American indian, Biack, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12 — Coilege (1-4or 5+): 0
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Neme *(First, Middle, Last)*: JAMES RARICK
18. Mother's Neme *(First, Middle, Maiden Surneme)*: MARY DAVIN

19e. informent's Neme/Reletionship *(Type, Print)*: CAROL CATE (DAUGHTER)
19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 251 GIBSON ROAD, PASADENA, MD 21122

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Name of cemetery, crematory or other piece)*: MT. VERNON CEMETERY
Dete: 5/30/97
20c. Location - City or Town, State: McKEESPORT, PA

21. Signeture of Funeral Service Licensee: [signature]
22. Neme end Address of Feciity: SINGLETON FUNERAL HOME 1 SECOND AVE. S.W., GLEN BURNIE, MD 21061

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the diseese, or complicetions thet caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heert failure. List only one cause on eech line.

Approximete intervai Between Onset and Death

Immediate Cause (Finei diseese or condition resulting in death)
e. ASPIRATION PNEUMONIA — 3 WKS

Due to (or es a consequence of):
b. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE — UNKNOWN

Sequentielly iist conditions, If eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Last

Due fo (or es a consequence of):
c. CEREBROVASCULAR ACCIDENT — UNKNOWN

Due to (or es e consequence of):
d. DEMENTIA — UNKNOWN

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings availebie prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medicai exeminer? 1☐ Yes 2☑ No

26. Piece of Deeth *(Check only one)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Yeer)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of injury - At home, farm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end manner es stated. 2☐ **Medicel Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete end piece, end due to the ceuse(s) end menner steted.

29b. Signeture and title of certifier: Savinder K Tulica MD
29c. License number: D27188
29d. Date signed *(Month, Day, Yeer)*: 5/24/97

30. Name and address of person who completed cause of death (item 23a) (Type, Print): SAVINDER K TULICA 2 Market Place Baltimore MD 21202

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: MAY 28 1997
32. Registrer's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17392

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): KENNETH GEORGE MEIDENBAUER
2. Date of Death: Month MAY Day 27 Year 1997
3. Time of Death: 8:35 AM.
4a. Facility Name (If not institution, give street and number): 491 BRIGHTWOOD ROAD
4b. City, Town, or Location of Death: MILLERSVILLE
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 060-22-5748
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 67 Yrs. | If Under 1 Yaar: Months / Deys | If Undar 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11-21-29
9. Birthplace (State or Foreign Country): NEW YORK

Usual Residence of Dacedant

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: MILLERSVILLE
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 491 BRIGHTWOOD ROAD
10f. Zip Code: 21108
10g. Citizen ot Whet Country?: U.S.A

11. Marital Stetus: 1 [ ] Nevar Merried 2 [X] Merried 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U,S. Armed Forces? 1 [X] Yes 2 [ ] No If Yas, Giva Yaar or Detes: 1948-52
13. Was Decedant ot Hispanic Origin? (Specify Yes or No- If Yas, specify Cuben, Maxican, Puarto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 | College (1-4or 5+): 4
16a. Decedent's Usuel Occupetion (Give kind of work dona during most of working life. DO NOT use ratired): ELECTRONIC ENGINEER
16b. Kind of Business/Industry: WESTINGHOUSE

17. Fether's Neme (First, Middle, Last): FRANK G. MEIDENBAUER
18. Mother's Nema (First, Middle, Melden Sumema): THERESA M. MEYER

19a. Interment's Name/Ralationship (Type, Print): MARION B. MEIDENBAUER
19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 491 BRIGHTWOOD ROAD, MILLERSVILLE, MD 21108

20a. Method ot Disposition: 1 [ ] Burial 2 [X] Cremetion 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Piece ot Disposition (Neme of cemetery, crametory or other piece): CHESAPEAKE CREMATORY
Dete: 5-28-97
20c. Location - City or Town, Stete: BELTSVILLE, MD

21. Signature of Funaral Service Licensee: Annie Burbell
22. Name and Address of Facility: SINGLETON FUNERAL HOME, PA 1 SECOND AVENUE S.W. GLEN BURNIE, MD 21061

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications thet caused the deeth. Do not antar tha mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onsat end Death

Immediate Ceuse (Final disaasa or condition resulting in deeth): e. HEPATIC FAILURE
Due to (or es e consequence of): CIRRHOSIS OF LIVER
Sequentially list conditions, if any, leading to immediete cause. Entar Underlying Cause (Diseese or injury thet initieted events resulting in daath) Last:
b. Due to (or es e consequence ot):
c. Dua to (or as a consaquance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No
24b. Were eutopsy findings availeble prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Deeth (Check only one): Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Homa 5 [X] Residence 8 [ ] Othar (Specify)
27. Mennar of Deeth: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Invastigation 6 [ ] Could not be determined
28a. Dete of Injury (Month, Dey Year)
28b. Tima of Injury
28c. Injury at Work? 1 [ ] Yas 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, tarm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Steta)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) end menner es stated. 2 [ ] **Medical Examiner**: On the besis ot exeminetion end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) end manner steted.

29b. Signature and title of certifier: D. Krell
29c. License number: D19151
29d. Dete signed (Month, Dey, Year): 5/27/97

30. Name and address of person who completed cause ot deeth (Item 23e) (Type, Print): GLENN ROBBINS 1600 CRAIN HWY S, STE 302, GLEN BURNIE, MD. 21061

State Registrar

31. Dete filed (Month, Dey, Year): MAY 28 1997
32. Registrer's Signeture: Julia Davidson-Randell

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: Tha law requires that tha death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by tha attending physician and completely filled in by tha funeral director, page 2 should be detached for usa as tha burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with tha Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 17393

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: John W. Martin
2. Date of Death Month Day Year: May 15, 1997
3. Time of Death: 0845
4a. Facility Name *(If not institution, give street and number)*: PENINSULA REGIONAL MEDICAL CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 214-28-7946
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 70 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 1-10-27
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Worcester
10c. City, Town or Location: Snow Hill
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 301 Church St. Apt 110
10f. Zip Code: 21863
10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8th; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Laborer
16b. Kind of Business/Industry: Saw Mill

17. Father's Name *(First, Middle, Last)*: Reuben T. Martin
18. Mother's Name *(First, Middle, Maiden Surname)*: Maggie Collick

19a. Informant's Name/Relationship *(Type, Print)*: Edward Martin
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 301 Church St., Snow Hill, Md. 21863

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. Wesley U.M. Church — Date: 5/20/97
20c. Location - City or Town, State: Snow Hill, Md.
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Bennie Smith Funeral Home 819 4th St, Pocomoke, Md.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Alcoholic Liver Disease; Malnutrition

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D29105
29d. Date signed *(Month, Day, Year)*: 5/15/97

30. Name and Address of person who completed cause of death (Item 23a) (Type, Print): Christian Huddleston MD 106 Milford St. Salisbury Md. 21801

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 21 1997
32. Registrar's Signature: [signature] Julia Davidson Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

John Martin SS# 214-28-7946

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17394

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY Emily MARTIN

2. Date of Death: Month MAY Day 14 Year 97

3. Time of Death: 1825

4a. Facility Name (If not institution, give street and number): Anne Arundel Medical Center

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 212-36-7669

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 06/22/1915

9. Birthplace (State or Foreign Country): Alabama

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 14 Hull Ave.

10f. Zip Code: 21403

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 4 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Elementary School teacher

16b. Kind of Business/Industry: State of Maryland Board of Education

17. Father's Name (First, Middle, Last): Not Available

18. Mother's Name (First, Middle, Maiden Surname): Not Available

19a. Informent's Neme/Relationship (Type, Print): Steven C. Martin (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4111 Indian River Dr. Vero Beach, Florida 32963

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, crematory or other piece): MD Veterans Cemetery

Date: 05/19/97

20c. Location - City or Town, State: Crownsville

21. Signature of Funeral Service Licensee: D. Adams

22. Name and Address of Facility: John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)

a. congestive heartfailure — 5 yrs

Due to (or as a consequence of):

b. HTN CVD — yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last

Due to (or as e consequence of):

c.

Due to (or as e consequence of):

d.

Pert ii. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Pert i.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Mennes of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and piece, end due to the cause(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) and manner stated.

29b. Signeture end title of certifier: Michael J. Preston MD

29c. License number: 021438

29d. Date signed (Month, Day, Year): 5/14/97

30. Name end address of person who completed cause of death (Item 23e) (Type, Print): MICHAEL J. PRESTON MD 1000 RIDGELY AVE STE 120 ANNAPOLIS MD 21403.

State Registrar

31. Dete filed (Month, Day, Year): MAY 20 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Meryland Department of Health end Mental Hygiene.

Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17395

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Raymond Carroll Massal
2. Date of Deeth Month: May Dey: 18, Yeer: 1997
3. Time of Deeth: 3:00AM
4e. Fecility Neme (If not institution, give street and number): Carroll County General Hospital
4b. City, Town, or Location of Death: Westminster
4c. County of Deeth: Carroll

Funeral Director

5. Sociel Security Number: 212-26-4997
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 68 Yrs. | If Under 1 Yeer: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Yeer): 3/6/1929
9. Birthplece (State or Foreign Country): Baltimore, Md.

Usuel Residence of Decedent

10e. Stete: Md.
10b. County: Carroll
10c. City, Town or Location: Finksburg
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street end Number: 2709 Appleseed Road
10f. Zip Code: 21048
10g. Citizen of Whet Country?: U.S.A.

11. Meritel Status: 1☐Never Merried 2☒Married 3☐Widowed 4☐Divorced
12. Wes Decedent Ever in U.S. Armed Forces?: 1☒Yes 2☐No If Yes, Give Year or Dates: 1948-1957
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.): 1☐Yes 2☒No Specify:
14. Reca - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 | College (1-4or 5+): 1
16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): electronics technician
16b. Kind of Business/Industry: AT&T Technology

17. Fether's Neme (First, Middle, Last): Joseph A. Massal
18. Mother's Name (First, Middle, Maiden Surname): Elizabeth M. Jaecksch

19e. Informent's Neme/Reletionship (Type, Print): Jean A. Massal / Wife
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2709 Appleseed Road Finksburg, Maryland 21048

20e. Method of Disposition: 1☒Burial 2☐Cremetion 3☐Removal from State 4☐Donetion 5☐Other (Specify)
20b. Piece of Disposition (Neme of cemetery, crematory or other place): Evergreen Mem. Gardens
Date: 5/21/1997
20c. Location - City or Town, Stete: Finksburg, Maryland

21. Signeture of Funeral Service Licensee: Jeffrey N. Zumbrun
22. Neme end Address of Fecility: Jeffrey N. Zumbrun Funeral Home 6028 Sykesville Road Sykesville, Maryland 21784

Physician /Medical Examiner

23a. Part I. Enter the diseese or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

		Approximete Intervel Between Onset end Deeth
Immediete Cause (Finel disease or condition resulting in death) e.	Myocardial Infarction	Ten hours
Due to (or es e consequence of):		
Sequentielly list conditions, if eny, leeding to Immediete cause. Enter Underlying Ceuse (Diseese or Injury thet Initieted events resulting in deeth) Last b.	Coronary Artery Disease	Ten years
Due to (or es e consequence of):		
c.		
Due to (or es e consequence of):		
d.		

Part II. **Other significent conditions** contributing to deeth but not resulting in the underlying cause given in Part I.: Seizure Disorder, Cerebral Vascular Accident

23b. Did tobacco use contribute to the cause of death?: 1☐Yes 2☐No 3☐Probably 4☑Unknown

24e. Wes en eutopsy performed?: 1☐Yes 2☑No

24b. Were autopsy findings eveileble prior to completion of cause of deeth?: 1☐Yes 2☑No

25. Wes case referred to medical exeminer?: 1☐Yes 2☑No

26. Piece of Death (Check only one): Hospitel: 1☑Inpetient 2☐ER/Outpetient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Deeth: 1☑Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work?: 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☑**Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end pleca, and due to the cause(s) end menner es stated. 2☐**Medicel Exeminer:** On the basis of exemineticn end/or investigetion, in my opinion, deeth occurred et the time, date end pleca, and due to the ceuse(s) end menner stated.

29b. Signeture and title of certifier: MD
29c. License number: D33184
29d. Dete signed (Month, Dey, Yeer): May 18, 1997

30. Neme and eddress of person who completed cause of death (Item 23e) (Type, Print): Jonathan Kushner MD 114 Business Center Pike Reistertown, MD

State Registrar

31. Dete filed (Month, Dey, Yeer): MAY 19 1997
32. Registrer's Signeture: Julia Hudson Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

30

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17396

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Lest)*: Lester Abraham Marks

2. Dete of Deeth Month / Day / Yeer: MAY / 16 / 1997

3. Time of Death: 2:17pm

4e. Feclity Neme *(If not institution, give streat and number)*: Harford Memorial Hospital

4b. City, Town, or Location of Deth: Havre de Grace

4c. County of Death: Harford

Funeral Director

5. Sociel Security Number: 039-03-3825

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthdey)*: 77 Yrs.

If Under 1 Yeer: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Yeer)*: Nov. 29, 1919

9. Birthplace *(Stete or Foraign Country)*: Rhode Island

Usuel Residence of Decedent

10a. Stata: Maryland

10b. County: Harford

10c. City, Town or Location: Joppa

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street end Number: 509 Anchor Drive

10f. Zip Code: 21085

10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Naver Married 2☒ Married 3☐ Widowed 4☐ Divorcad

12. Was Decedent Evar in U.S. Armed Forcas? 1☒ Yes 2☐ No If Yes, Give Yaar or Dates: 1937-1957

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.): 1☐ Yes 2☒ No *Specify:*

14. Race - Americen Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Spacify only highest grede completed)*: Elementary/Secondery (0-12): 12 / College (1-4or 5+):

16e. Decedent's Usual Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Photographer

16b. Kind of Business/Industry: U.S. Government

17. Fether's Neme *(First, Middle, Last)*: Joseph (NMN) Marks

18. Mother's Name *(First, Middle, Meiden Sumame)*: Annie (NMN) Goldstein

19a. Informent's Neme/Reletionship *(Type, Print)*: Leone P. Marks/Wife

19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 10566 Twin Rivers Road, Columbia, MD 21044

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donetion 5☐ Other *(Spacify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other pleca)*: Arlington National Cem.

Dete: 5/22/97

20c. Location - City or Town, Steta: Arlington, Virginia

21. Signature of Funeral Service Licensee: Howard K. McComas III

22. Neme end Address of Facility: Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009

Physician /Medical Examiner

23a. Part1. Enter the diseesa, or complications that caused tha daath. Do not entar the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one ceuse on eech line.

Approximata Interval Between Onset end Death

Immediate Cause (Finel disaase or condition resulting in death): e. Myocardial infarction

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest:

b. Coronary artery disease — 3 years

Due to (or es e consequenca of):

c.

Due to (or es a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying ceuse givan in Part I.: none

23b. Did tobacco uee contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performad? 1☐ Yes 2☒ No

24b. Were eutopsy findings availeble prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No

26. Plece of Death *(Check only one)*: Hospitel: 1☐ inpatient 2☒ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of exemination end/or investigetion, in my opinion, deeth occurred et the time, date and placa, end due to the ceuse(s) and manner steted.

29b. Signatura and title of certifier: Victor Ferzoco MD

29c. Licensa number: D46296

29d. Date signed *(Month, Day, Year)*: May 20, 1997

30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print): Victor Ferzoco MD, 502 Eastern Blvd. Baltimore, Maryland 21221

State Registrar

31. Dete filed *(Month, Day, Year)*: MAY 21 1997

32. Registrer's Signeture: Gabi Duncan-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mentel Hygiene. **Important: If item 27 is marked other than "natural', or items 23a or 28-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Lester Abraham Marks

17

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17397

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): STELLA S. McCRACKEN
2. Date of Death Month: 05 Day: 11 Year: 97
3. Time of Death: 8:30 a.m.
4a. Facility Name (If not institution, give street and number): 3813 Salem Church Road
4b. City, Town, or Location of Death: Jarrettsville
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 214-26-1452
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 67 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 8/24/29
9. Birthplace (State or Foreign Country): Ballsville, VA

Usual Residance of Decadant

10a. Steta: Maryland
10b. County: Harford
10c. City, Town or Location: Jarrettsville
10d. Insida City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3813 Salem Church Road
10f. Zip Coda: 21084
10g. Citizan of What Country?: United States

11. Meritel Stetus: 1☐ Never Merried 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yas, Giva Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Maxican, Puarto Rican, atc.): 1☐ Yas 2☒ No Specify:
14. Race - Amarican Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grada complated): Elamantary/Secondary (0-12): 8 | Collaga (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired): Budget Analyst
16b. Kind of Business/Industry: Civil Service

17. Fathar's Nama (First, Middle, Last): Everett Sumner
18. Mothar's Nama (First, Middle, Maidan Surnama): Essie Cook

19a. Informant's Name/Relationship (Type, Print): Elaine Cook/Daughter
19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 3813 Salem Church Road, Jarrettsville, MD

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)
20b. Place of Disposition (Nama of cematary, cramatory or othar place): Green Hill Cemetery
Data: 5/15
20c. Location - City or Town, Steta: Waynesville, NC

21. Signature of Funaral Service Licensee: Jeffrey P. Lantz
22. Nama and Address of Facility: Harkins Funerla Home, Inc., Delta, PA

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

26a. Part I. Enter the diseasa, or complicetions thet causad tha death. Do not enter the mode of dying, such es cardiac or raspiretory errast, shock, or haart failure. List only ona causa on aach lina.

Approximate Interval Batwaan Onset and Death

Immediata Causa (Final diseesa or condition resulting in death): a. CANCER RENAL PELVIS — Approximate Interval: 4 Months

Dua to (or as a consequance of):

Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Causa (Disaasa or injury that initiated evants resulting in death) Last:
b.
Dua to (or as a consaquanca of):
c.
Dua to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Ware autopsy findings aveilable prior to completion of cause of daath? 1☐ Yas 2☑ No

25. Was casa rafarred to madical examinar? 1☐ Yas 2☑ No

26. Placa of Death (Check only ona): Hospital: 1☐ inpatient 2☐ ER/Outpatient 3☐ DOA — Othar: 4☐ Nursing Home 5☑ Residence 6☐ Othar (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be datarmined

28a. Data of Injury (Month, Day Year)
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28a. Placa of Injury - At homa, farm, streat, factory, offica building, atc. (Specify)
28f. Location (Streat and Number or Rural Route Number, City or Town, State)

29a. Cartifiar (Check only one): 1☑ **Certifying Physician**: To the best of my knowledga, death occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner**: On tha basis of axamination and/or investigation, in my opinion, death occurred at tha tima, data and piaca, and dua to tha causa(s) and mannar stated.

29b. Signatura and title of certifiar:
29c. Licansa number: D29071
29d. Data signed (Month, Day, Year): 5-12-97

30. Nama and address of person who completed causa of death (Item 23a) (Type, Print): R. KRISHNAN, MD 821 N. EUTAW ST # 305 BALTIMORE MD 21201

State Registrar

31. Data filed (Month, Day, Year): MAY 19 1997
32. Registrar's Signatura:

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that tha death certificata be executed within 24 hours after death.
To the Funeral Director: After this certificata has been signed by tha attending physician and completely filled in by tha funaral director, paga 2 should be datached for usa as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17398

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EARTHA L. MARTIN

2. Date of Death: Month May Day 18 Year 1997

3. Time of Death: 6:00 PM

4a. Facility Name (If not institution, give street and number): Regency Nursing Home

4b. City, Town, or Location of Death: Forestville

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 247-48-7745

6. Sex: 1☐ M 2☒ F

7. Age (in yrs. last birthday): 71 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 03-17-1926

9. Birthplace (State or Foreign Country): South Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Capitol Heights

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 5827 Coolidge Street

10f. Zip Code: 20743

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Elevator Operator

16b. Kind of Business/Industry: Government

17. Father's Name (First, Middle, Last): Wesley Bowman

18. Mother's Name (First, Middle, Maiden Surname): Edna Brown

19a. Informant's Name/Relationship (Type, Print): James Martin, Sr./Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5827 Coolidge St, Capitol Heights, MD 20743

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, cremetory or other place): Harmony Memorial Park

Date: 05/24 1997

20c. Location - City or Town, State: Landover, Maryland

21. Signature of Funeral Service Licensee:

22. Name and Address of Facility: J. B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE

Due to (or as a consequence of):

b. multiple strokes >2-years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Diabetes mellitus.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D-34525

29d. Date signed (Month, Day, Year): 05-19-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): S-J-RAO, MD ; 4000-Mitchellville Road ; #220 Bowie MD 20716

State Registrar

31. Date filed (Month, Day, Year): MAY 20 1997

32. Register's Signature: Julia Strudwick Randall

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17399

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Wesley Grindell Martin

2. Date of Death Month: May Day: 14 Year: 1997

3. Time of Death: 12:05 pm

4a. Facility Name *(If not institution, give street and number)*: Collington Episcopal Life Care Center

4b. City, Town, or Location of Death: Mitchellville

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 389-03-5207

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 92 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sept. 22, 1904

9. Birthplace *(State or Foreign Country)*: Wisconsin

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Mitchellville

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 10450 Lottsford Road

10f. Zip Code: 20721

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Chemical Engineer

16b. Kind of Business/Industry: A.O. Smith - Milwaukee

17. Father's Name *(First, Middle, Last)*: George Edward Martin

18. Mother's Name *(First, Middle, Maiden Surname)*: Lydia Grindell

19a. Informant's Name/Relationship *(Type, Print)*: Carolyn M. Miller, Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4122 Woodberry Street, Hyattsville, Maryland 20782

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory Date: 5/16/97

20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Henry L. Tarl

22. Name and Address of Facility: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave. Hyattsville MD. 20781

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errast, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cerebrovascular Accident — 2 weeks

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: St MD

29c. License number: D37934

29d. Date signed *(Month, Day, Year)*: 5/16/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephanie Trifoglio MD 7500 Greenway Center Drive Greenbelt MD 20770

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 22 1997

32. Registrar's Signature: John Sheridan Cordell

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

15

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17400

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LARVENIA MCDOUGAL

2. Date of Death: Month MAY Day 20 Year 1997

3. Time of Death: 12:55AM

4a. Facility Name (If not institution, give street and number): Montgomery General HOspital

4b. City, Town, or Location of Death: Olney

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-26-6201

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): March 16, 1922

9. Birthplace (State or Foreign Country): North Carolina

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1☒ Yas 2☐ No

10e. Street and Number: 472 College Parkway Apt. #203

10f. Zip Code: 20850

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest greda completed): Elementary/Secondary (0-12): 12th grade; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired): Supervisor

16b. Kind of Businass/Industry: Sterling Dry Cleaners (Retired

17. Father's Name (First, Middle, Last): Harvey Pass

16. Mothar's Name (First, Middle, Maiden Surneme): Roxie McCrimmon

19a. Informant's Name/Relationship (Type, Print): Mrs. Bertha Bligen (Grand-Daughter)

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 552 College Parkway Rockville, Maryland 20850

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Ramoval from State 4☐ Donation 5☐ Othar (Specify)

20b. Place of Disposition (Nema of cemetery, cramatory or othar place): National Harmony Memorial Park

Date: 5/24/97

20c. Location - City or Town, Stata: Landover, Maryland

21. Signature of Funaral Service Licensee: Janet C. Anderson

22. Name and Address of Facility: Rollins Funeral HOme, Inc. 4339 Hunt Place, N.E. Washington, D.C. 20019

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused tha death. Do not entar the mode of dying, such as cardiac or raspiratory arrest, shock, or haart failure. List only ona causa on each line.

		Approximate Interval Between Onset and Death
Immediate Causa (Final disease or condition resulting in death) a.	CANDIDA SEPSIS	14 DAYS
Due to (or as a consequenca of): b.	PNEUMONIA	46 DAYS
Sequentially list conditions, if any, leading to immadiata cause. Entar Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Dua to (or as a consequenca of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residance 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At homa, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Routa Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and dua to the cause(s) and manner as atated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to tha cause(s) and manner stated.

29b. Signature and title of certifier: Abeda khan M.D.

29c. License number: D43323

29d. Data signed (Month, Day, Year): MAY 20, 1997

30. Name and address of peraon who completed cause of death (Item 23a) (Type, Print): ABEDA KHAN M.D. SUITE 212, 18111 PRINCE PHILIP DRIVE, OLNEY MD 20832

State Registrar

31. Date filed (Month, Day, Year): MAY 23 1997

32. Registrar's Signature: Julie Davidson Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(2)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17401

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: WILLIAM Stuart MORRIS Sr.

2. Deta of Death Month: May Dey: 6 Yeer: 1997

3. Time of Death: 8:42a.m.

4e. Facility Neme *(If not institution, give street end number)*: St. Mary's Hospital

4b. City, Town, or Location of Deeth: Leonardtown

4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 215-38-5618

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 58 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Yeer)*: Nov. 10, 1938

9. Birthplece *(Stete or Foreign Country)*: Maryland

Usuel Residence of Decedent

10a. Stete: MD

10b. County: St. Mary's

10c. City, Town or Location: Avenue

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 37409 River Spring Road

10f. Zip Coda: 20609

10g. Citizen of Whet Country?: USA

11. Meritel Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yas 2☒ No *Specify:*

14. Race - Americen Indian, Black, White, etc. *Specify:* White

15. Decedent's Educetion *(Specify only highest grade completed)*: Elemantary/Secondery (0-12): 12 / College (1-4or 5+):

16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Waterman

16b. Kind of Business/Industry: Seafood

17. Fether's Name *(First, Middle, Last)*: Charles Stuart Morris

18. Mother's Neme *(First, Middle, Meiden Surneme)*: Ruth Alma Brown

19e. Informant's Name/Reletionship *(Type, Print)*: Rose Marie Morris Wife

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 37409 River Spring Road, Avenue, MD 20609

20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Sacred Heart Cemetery

Date: 5/9/1997

20c. Location - City or Town, State: Bushwood, MD

21. Signature of Funeral Service Licensee: ▶ Michael K. Gardiner

22. Neme end Address of Feciility: Mattingley-Gardiner Funeral Home, P.A. P.O.Box 270, Leonardtown, MD 20650

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one ceuse on eech lina.

Approximete Intervel Between Onset end Death

Immedieta Ceuse (Finel diseese or condition resulting in death)

a. T-cell lymphoma, non-Hodgkin's — 13 MO.

Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to Immediate ceusa. Enter Underlying Cause (Disaasa or Injury thet initiated events resulting in deeth) Lest

b.

Due to (or es e consequence of):

c.

Due to (or es e consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

Anemia

thrombocytopenia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Was an eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings aveilable prior to completion of ceuse of daeth? 1☐ Yes 2☐ No

25. Wes cese referrad to medicel exeminer? 1☐ Yes 2☒ No

26. Piece of Death *(Check only one)*: Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28e. Date of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To tha bast of my knowledga, daath occurred et tha tima, date end plece, end dua to tha ceuse(s) end mennar as statad. 2☐ **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, death occurred et tha time, data and place, and due to tha ceuse(s) and mennar stated.

29b. Signature and title of certifier: ▶ John J. Fenwick

29c. License number: D01380

29d. Dete signed *(Month, Dey, Yeer)*: 5-7-97

30. Nema end address of parson who completed cause of daeth (Item 23a) (Type, Print): DR. JOHN FENWICK ST. MARY'S MEDICAL ARTS BLDG. LEONARDTOWN, MD 20650

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(12)

State Registrar

31. Dete filed *(Month, Day, Yeer)*: MAY 08 1997

32. Registrer's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17402

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Margaret Jane Mattingly
2. Date of Death Month: May Day: 12 Year: 1997
3. Time of Death: 11:35 PM
4a. Facility Name *(If not institution, give street and number)*: Physicians Memorial Hospital
4b. City, Town, or Location of Death: La Plata
4c. County of Death: Charles

Funeral Director

5. Social Security Number: 215-70-8028
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 60 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jan 5, 1937
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Hollywood
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 24746 Old Three NotchRoad
10f. Zip Code: 20636
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9th Grade — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Joseph Elthbert Abell
18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Louise Wood

19a. Informant's Name/Relationship *(Type, Print)*: William C. Mattingly, Sr.
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 24746 Old Three NotchRoad, Hollywood, MD 20636

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St. John's Cemetery
Date: 5/16/97
20c. Location - City or Town, State: Hollywood, MD

21. Signature of Funeral Service Licensee: Michael K. Gardiner
22. Name and Address of Facility: Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Multisystem Organ failure — 3 days
Due to (or as a consequence of):
b. Gangrene both lower extremities — 5 days
Due to (or as a consequence of):
c. Severe peripheral Vascular disease — weeks.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Obesity
Renal insufficiency
Status post Multiple bypasses.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*: N/A
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: N/A
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: P. Sahdev MD
29c. License number: D-47202
29d. Date signed *(Month, Day, Year)*: 5/13/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Pradip Sahdev, MD., 11340 Pembrooke Square, Suite 213, Waldorf, Maryland 20603

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 16 1997
32. Registrar's Signature: Lois Davidson-Randall

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17403

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Adele Mattingly
2. Date of Death (Month Day Year): May 18 1997
3. Time of Death: 1:15 AM
4a. Facility Name (If not institution, give street and number): St. Mary's Hospital
4b. City, Town, or Location of Death: Leonardtown
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 218-14-3296
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 75 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jul 31, 1921
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Leonardtown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 42237 St. Andrews Church Rd., POB 69
10f. Zip Code: 20650
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Switchboard Operator
16b. Kind of Business/Industry: Hospital

17. Father's Name (First, Middle, Last): Richard Martin Woodburn, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Beatrice Marie Norris

19a. Informant's Name/Relationship (Type, Print): Thomas A. Mattingly/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 173, Leonardtown, MD 20650

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Charles Memorial Gardens
Date: 5/20/97
20c. Location - City or Town, State: Leonardtown, MD

21. Signature of Funeral Service Licensee: ▶ Michael K Gardiner
22. Name and Address of Facility: Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Cardiac Arrest 2' to	~ 25 min
Due to (or as a consequence of): b.	Acute hypotension 2' to	3-4 hrs.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: Due to (or as a consequence of): c.	Right Hemothorax	3-4 hrs.
Due to (or as a consequence of): d.	(MOST Likely)	

Part ii. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Ø Small Bowel Obstruction and gangrene

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 8☒ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]
29c. License number: D36206
29d. Date signed (Month, Day, Year): 05/19/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kiran Mehta, M.D. Leonardtown, MD 20650

State Registrar

31. Date filed (Month, Day, Year): MAY 19 1997
32. Registrar's Signature: [signature] Julia Davidson-Randall

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Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed/filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

(7)

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17404

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY MOALS

2. Date of Death: Month MAY Day 18 Year 1997

3. Time of Death: 1920 PM

4a. Facility Name (If not institution, give street and number): St. Agnes Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 216 30 3609

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 99 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 13, 1897

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 402 Colleen Road Apt. B

10f. Zip Code: 21229

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc.: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Domestic

17. Father's Name (First, Middle, Last): James Quickley

18. Mother's Name (First, Middle, Maiden Surname): Rebecca Howard

19a. Informant's Name/Relationship (Type, Print): Dorothy Moals

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 402 Colleen Road Apt. B Baltimore, Md. 21229

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Long Green A.M.E.Cemetery

Date: 5/22/97

20c. Location - City or Town, State: Monkton, Md.

21. Signature of Funeral Service Licensee: ▶ Harry W. Haight

22. Name and Address of Facility: Haight Funeral Home P.O.Box 195 Sykesville, Md. 21784

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. possible acute myocardial infarct — 10 minutes

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

coronary artery disease

anemia

dementia

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

28. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ K. Chantornsaeng, MD

29c. License number: PO-9145

29d. Date signed (Month, Day, Year): MAY 18, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): K. CHANTORNSAENG ST. AGNES HOSPITAL 900 CATON AVE. BALTIMORE, MD

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): MAY 20 1997

32. Registrar's Signature: Julia Gardner Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 17405

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary Jane Mullen
2. Date of Death Month May Day 22, Year 1997
3. Time of Death: 5:20 PM
4a. Facility Name *(If not institution, give street and number)*: St. Mary's Nursing Center
4b. City, Town, or Location of Death: Leonardtown
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 219-12-2676
6. Sex: 1☐ M 2■ F
7. Age *(In yrs. last birthday)*: 74 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: April 15,1923
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Lexington Park
10d. Inside City Limits: 1☐ Yes 2■ No
10e. Street and Number: 913 Hilton Drive
10f. Zip Code: 20653
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3■ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2■ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2■ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Assistant Manager/Bookkeeper
16b. Kind of Business/Industry: Banking

17. Father's Name *(First, Middle, Last)*: James Rufus King
18. Mother's Name *(First, Middle, Maiden Surname)*: Della Waters Woodfield

19a. Informant's Name/Relationship *(Type, Print)*: Judith M. Ertter, Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 13036 Limestone Court, Clifton, Virginia 20124

20a. Method of Disposition: 1■ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: St. George Church Cemetery — Date: 5-27-97
20c. Location - City or Town, State: Valley Lee, Maryland

21. Signature of Funeral Service Licensee: Edward R. Brinsfield, Jr., MD0052
22. Name and Address of Facility: Brinsfield Funeral Home, P.A. 22955 Hollywoood Road, Leonardtown, Maryland 20650-0279

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not antar tha moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
e. Acute Pneumonia — 1wk

Due to (or as a consequence of):
b. Subarachnoid Hemorrage with Dementia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1■ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D19917
29d. Date signed *(Month, Day, Year)*: 5/23/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James C. Boyd, MD, 2050 Wildewood Center, California, Maryland 20619

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 27 1997
32. Registrar's Signature: Julie Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended item 4b per F.D. 5/20/97, Carroll Co., wjl

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17406

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month / Day / Year	3. Time of Death
Bruce	Martz	May 19, 1997	8:16am

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1636 Deer Park Road	~~Finksburg~~ Finksburg	Carroll

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-66-2886	1 [X] M 2 [ ] F	34 Yrs.			May 16, 1963	Maryland

Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md	Carroll	Finksburg	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1636 Deer Park Road	21048	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
5		laborer	clerical

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
George K. Martz	Dorothy Wilson

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Dorothy Wilson (mother)	1636 Deer Park Rd. Finksburg, Md. 21048

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Lake View Mem. Park	5-23-97	Sykesville

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Brian L. Haight	HAIGHT FUNERAL HOME & CHAPEL (Box195) Sykesville, MD 21784 (410)-795-1400

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Sepsis	3-4 Days
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Down's Syndrome

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown	1 [X] Yes 2 [ ] No	1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [X] Yes 2 [ ] No	Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of Certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D37444	5-19-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alexandra Bacelis-Sheppard 1425 Liberty Rd. Suite 208 Eldersburg MD 21784

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 20 1997	Julia Anderson Randall

State Registrar

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17407

Physician /Medical Examiner

1. Decadant's Nama (First, Middle, Last): Ralph William Morrison
2. Data of Daath — Month: May; Day: 19; Yaar: 1997
3. Tima of Death: 23:15
4a. Facility Nama (If not institution, giva street and numbar): Carroll County General Hospital
4b. City, Town, or Location of Daath: Westminster
4c. County of Daath: Carroll

Funeral Director

5. Social Sacurity Numbar: 215-32-2096
6. Sax: 1 ☒ M 2 ☐ F
7. Aga (In yrs. last birthday): 84 Yrs. — If Undar 1 Yaar: Months / Days; If Undar 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Yaar): Jan. 31, 1913
9. Birthplaca (State or Foreign Country): Maryland

Usual Rasidanca of Dacadant

10a. Stata: Maryland
10b. County: Carroll
10c. City, Town or Location: Westminster
10d. Insida City Limits: 1 ☒ Yas 2 ☐ No
10a. Straat and Numbar: 25 Union Street
10f. Zip Coda: 21157
10g. Citizan of What Country?: United States

11. Marital Status: 1 ☐ Navar Marriad 2 ☐ Marriad 3 ☒ Widowad 4 ☐ Divorcad
12. Was Dacadant Evar in U.S. Armed Forcas? 1 ☐ Yas 2 ☒ No — If Yas, Giva Yaar or Datas:
13. Was Dacadant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1 ☐ Yas 2 ☒ No Specify:
14. Race - Amarican Indian, Black, White, atc. Specify: Black

15. Dacadant's Education (Specify only highest grade completed): Elamantary/Sacondary (0-12): 6th grade; Collaga (1-4or 5+):
16a. Dacadant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Custodian/Maintenance
16b. Kind of Businass/Industry: Public School

17. Fathar's Nama (First, Middle, Last): William Morrison
18. Mothar's Nama (First, Middle, Maidan Surnama): Grace Brown

19a. Informant's Name/Ralationship (Type, Print): Delores Barbour, daughter
19b. Mailing Addrass (Street and Numbar or Rural Routa Numbar, City or Town, State, Zip Coda): 587 Center Drive, Chambersburg, PA. 17201

20a. Mathod of Disposition: 1 ☒ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify)
20b. Placa of Disposition (Nama of camatary, crematory or other placa): Fairview Cemetery
Data: 5-23-97
20c. Location - City or Town, Stata: Taylorsville, MD.

21. Signatura of Funaral Sarvica Licansaa: Katherine Pritts-Sweitzer
22. Nama and Addrass of Facility: Pritts Funeral Home & Chapel, 412 Washington Rd. Westminster, MD 21157

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that causad tha daath. Do not antar tha mada of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina.

Approximata Intarval Batwaan Onsat and Death

Immadiata Causa (Final disaasa or condition rasulting in daath)
a. ASPIRATION PNEUMONIA — 1 week
Dua to (or as a consaquanca of):
b. COMA — 1 week

Saquantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or Injury that Initiatad avants rasulting in daath) Last
Dua to (or as a consaquanca of):
c.
Dua to (or as a consaquanca of):
d.

Part II. **Othar significant conditions** contributing to death but not rasulting in tha undarlying causa given in Part I.
Cancer Nasopharynx prostate

23b. Did tobacco usa contributa to the cause of death? 1 ☐ Yas 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yas 2 ☒ No
24b. Wara autopsy findings availabla prior to complation of causa of daath? 1 ☐ Yas 2 ☐ No

25. Was casa rafarrad to madical examinar? 1 ☐ Yas 2 ☒ No
26. Placa of Death (Check only one): Hospital: 1 ☒ Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA; Othar: 4 ☐ Nursing Hama 5 ☐ Rasidanca 6 ☐ Othar (Specify)

27. Mannar of Death: 1 ☒ Natural 2 ☐ Accidant 3 ☐ Suicida 4 ☐ Homicida 5 ☐ Panding Invastigation 6 ☐ Could not be determinad
28a. Data of Injury (Month, Day, Yaar)
28b. Tima of Injury M
28c. Injury at Work? 1 ☐ Yas 2 ☐ No
28d. Dascribe how injury occurrad
28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify)
28f. Location (Street and Numbar or Rural Routa Numbar, City or Town, State)

29a. Cartifiar (Check only one): 1 ☒ **Cartifying Physician:** To tha best of my knowladga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2 ☐ **Madical Examinar:** On tha basis of axaminetion and/or invastigetion, in my opinion, daath occurrad at tha tima, data and placa, and dua to the causa(s) and mannar stated.

29b. Signatura and tita of cartifiar: Chitrachedu Naganna
29c. Licansa numbar: D18 20c
29d. Data signad (Month, Day, Yaar): 5/21/97

30. Nama and addrass of parson who compilatad causa of daath (Itam 23a) (Type, Print): CHITRACHEDU NAGANNA MD. 700-A poole Rd WESTMINSTER MD 21157

State Registrar

31. Data filad (Month, Day, Yaar): MAY 22 1997
32. Registrar's Signatura: Julie Davidson Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

97 17408

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LOUISE ANNA METZ			2. DATE OF DEATH (Month, Day, Year): MAY 27, 1997	3. TIME OF DEATH: 6:20 A. M
4. SOCIAL SECURITY NUMBER: 214-09-3179	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 90 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Dec.15,1906	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): COFFMAN NURSING HOME		9b. CITY, TOWN OR LOCATION OF DEATH: Hagerstown	9c. COUNTY OF DEATH: Washington	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Washington	10c. CITY, TOWN OR LOCATION: Hagerstown	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 11 West Baltimore Street		10f. ZIP CODE: 21740	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+): 0	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): homemaker	16b. KIND OF BUSINESS/INDUSTRY: her own home	
17. FATHER'S NAME (First, Middle, Last): Albertus Baker		18. MOTHER'S NAME (First, Middle, Maiden Surname): Julia D. Warner	
19a. INFORMANT'S NAME (Type/Print): Jerry P. Metz - son		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12018 Mapleville Rd., Cavetown, Md. 21720	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Rose Hill Cemetery DATE: 5-30-97	20c. LOCATION — City or Town, State: Hagerstown, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Scott Minnich		22. NAME AND ADDRESS OF FACILITY: MINNICH FUNERAL HOME 415 E.Wilson Blvd.,Hagerstown,Md. 21740	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Gastrointestinal Bleed	7 days
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

S/P Stroke; Atrial fibrillation; Congestive heart failure

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Samuel Chan	29c. LICENSE NUMBER: D36655	29d. DATE SIGNED (Month, Day, Year): ▶ 5/27/97
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SAMUEL CHAN, M.D. 1185 MT. AETNA ROAD, HAGERSTOWN, MD 21740		
31. DATE FILED (Month, Day, Year): MAY 29 1997	32. REGISTRAR'S SIGNATURE: Julia Hardesty Rockell	

DHMH-18 Rev 1/89

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17409

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MAURICE EUGENE MYERS

2. Date of Death Month Day Year: May 22 1997

3. Time of Death: 16:51

4a. Facility Name (If not institution, give street and number): WASHINGTON COUNTY HOSPITAL

4b. City, Town, or Location of Death: HAGERSTOWN

4c. County of Death: WASHINGTON

Funeral Director

5. Social Security Number: 220-42-5573

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 52 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): APRIL 7, 1945

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: WASHINGTON

10c. City, Town or Location: SHARPSBURG

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3428 HARPERS FERRY ROAD

10f. Zip Code: 21782

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): WELDER

16b. Kind of Business/Industry: INDUSTRIAL SUPPLIER

17. Father's Name (First, Middle, Last): DAVID W. MYERS

18. Mother's Name (First, Middle, Maiden Surname): PHYLLIS MYERS

19a. Informant's Name/Relationship (Type, Print): LINDA L. MYERS/SPOUSE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3428 HARPERS FERRY ROAD, SHARPSBURG, MARYLAND 21782

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, cremetory or other piece): SAMPLES MANOR CEMETERY

Date: 5/25/97

20c. Location - City or Town, State: SAMPLES MANOR, MARYLAND

21. Signature of Funeral Service Licensee: Paul M. Dean

22. Name and Address of Facility: BAST FUNERAL HOME 7606 Old National Pike Boonsboro, Maryland 21713

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or haart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFARCTION — 1 DAY

Due to (or as a consaquance of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — YEARS

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS, TYPE II

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year): NONE

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: , MD

29c. License number: D01040

29d. Date signed (Month, Day, Year): 05-23-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BARRY M. COHEN, MD 18706 CRESTWOOD DRIVE HAGERSTOWN, MD, 21742

State Registrar

31. Date filed (Month, Day, Year): MAY 23 1997

32. Registrar's Signature: Julia Bowlus Rudell

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Myers, Maurice Eugene

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended #7,8, CAC Kent Co.

Certificate of Death

Reg. No. 97 17410

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Ann Moore
2. Date of Death: Month May Day 21 Year 1997
3. Time of Death: 12:42pm
4a. Facility Name (If not Institution, give street and number): The Kent and Queen Anne's Hospital
4b. City, Town, or Location of Death: Chestertown
4c. County of Death: Kent

Funeral Director

5. Social Security Number: 218-18-2248
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): ~~74~~ 76 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): August 2, ~~1922~~ 1920
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Queen Annes
10c. City, Town or Location: Chestertown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: P. O. Box 391, Chester Harbor
10f. Zip Code: 21620
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nurses Aid
16b. Kind of Business/Industry: Medical

17. Father's Name (First, Middle, Last): Edward Maslin
18. Mother's Name (First, Middle, Maiden Surname): Mamie Louise Witlock

19a. Informant's Name/Relationship (Type, Print): Ruth Kelley/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 128 Melodic Drive, Newark, Delaware 19713

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Massey Cemetery/May 24, 1997
20c. Location - City or Town, State: Massey, Maryland

21. Signature of Funeral Service License: [signature] M00937
22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Cardiac Arrest — 15 hrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Acute Anterior MI & Likely Septal Rupture

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: HTN

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D.
29c. License number: D0050996
29d. Date signed (Month, Day, Year): 5/21/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Neil Stoddard MD 100 Brown St. Chestertown MD 21620

State Registrar

31. Date filed (Month, Day, Year): MAY 23 '97
32. Registrar's Signature: Gina Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17411

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Frances Ruth McKnight

2. Date of Death: Month May Day 19, Year 1997

3. Time of Death: 12:05 p.m.

4a. Facility Name (If not institution, give street and number): Magnolia Hall Nursing Home

4b. City, Town, or Location of Death: Chestertown

4c. County of Death: Kent

Funeral Director

5. Social Security Number: 217-92-8450

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): December 5, 1923

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Kent

10c. City, Town or Location: Chestertown

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 200 Morgnec Road

10f. Zip Code: 21620

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decadant's Education (Specify only highest greda completed): Elamantary/Secondary (0-12): 0; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired):

16b. Kind of Business/Industry:

17. Father's Name (First, Middle, Last): William R. McKnight

18. Mother's Name (First, Middle, Meiden Surname): Louise G. McCullough

19a. Informent's Name/Relationship (Type, Print): Marjorie McKnight Clements/Sister

19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code): 42 Woodland Court, Seaford, Delaware 19973-3645

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Ramovel from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other place): Chesapeake Cremation Center, LLC

Date: May 20, 1997

20c. Location - City or Town, Stete: Stevensville, Maryland

21. Signeture of Funeral Service Licensee: Gary B Fellows

22. Name end Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert failure. List only one cause on each line.

Approximate Intervel Batwaan Onset end Death

Immediete Cause (Finel diseese or condition resulting in death)

e. Arteriosclerotic Cardiovascular Disease 10 years

Due to (or es e consaquance of):

Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in daath) Lest

b.

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

Mental Retardation

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John K Ross MD

29c. License number: D1703C - MD

29d. Date signed (Month, Day, Year): 5/19/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John K. Ross MD 516 Washington Ave Chestertown MD 21620

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State Registrar

31. Date filed (Month, Day, Year): MAY 21 '97

32. Registrar's Signature: Julia Davidson-Randall

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17412

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Isabelle McConville
2. Date of Death Month/Day/Year: May 18, 1997
3. Time of Death: 1:45 pm
4a. Facility Name (If not institution, give street end number): Citizens Nursing Home
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 226-44-8980
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov 18, 1913
9. Birthplace (State or Foreign Country): Austria-Hungary

Usual Residence of Decedent

10e. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Adamstown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 2301 Mount Ephriam Road
10f. Zip Code: 21710
10g. Citizen of Whet Country?: U.S.A.

11. Maritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - Americen Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | Collega (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cafeteria
16b. Kind of Business/Industry: Public School

17. Father's Name (First, Middle, Last): Frank KOSMAN
18. Mother's Name (First, Middle, Meiden Surneme): Kathrine MAHACHEK

19a. Informent's Name/Relationship (Type, Print): Mrs. Kathleen M. Reen/Daughter
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 2301 Mount Ephriam Road, Adamstown, Maryland 21710

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other place): Arlington National Cemetery
Date: May 28,1997
20c. Location - City or Town, State: Ft. Myer, VA

21. Signature of Funerel Service Licensee: Kathlynn R. Reen M00706
22. Neme end Address of Fecility: Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, Maryland 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complicetions thet ceused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heert failure. List only one ceuse on eech line.

		Approximete Interval Between Onset and Death
Immediate Ceuse (Final disease or condition resulting in deeth) e.	Pneumonia.	1wk.
Due to (or es a consequence of):		
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	Alzheimers Disease	3yr.
Due to (or es a consequence of):		
c.		
Due to (or es e consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings evellable prior to completion of ceuse of death? 1☐ Yes 2☒ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28e. Date of Injury (Month, Day Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner es stated. 2☐ **Medical Examiner:** On the beels of examination and/or investigation, in my opinion, death occurred et the time, dete and place, and due to tha ceuse(s) end manner steted.

29b. Signature and title of certifier: Robert L. Kaufmann
29c. License number: D13971
29d. Dete signed (Month, Day, Year): May 19, 1997

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): Robert L. Kaufmann, M.D., 300 West Ninth Street, Frederick, Maryland 21701

State Registrar

31. Date filed (Month, Dey, Yeer): MAY 20 1997
32. Registrar's Signature: Linda Sheridan-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17413

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: GENE G. MORGAN

2. Date of Death — Month: MAY Day: 18, Year: 1997

3. Time of Death: 9:30 AM

4a. Facility Name *(If not institution, give street and number)*: Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 219-34-5541

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 60 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct. 19, 1936

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Monrovia

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 3403 Kemptown Church Road

10f. Zip Code: 21770

10g. Citizen of What Country?: American

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1955-57

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Machinist Inspector

16b. Kind of Business/Industry: U.S. Government

17. Father's Name *(First, Middle, Last)*: Dale Benton

18. Mother's Name *(First, Middle, Maiden Surname)*: Lottie Rae

19a. Informant's Name/Relationship *(Type, Print)*: B. Jane Morgan - Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3403 Kemptown Church Road, Monrovia, Maryland 21770

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Damascus Methodist Ceme. Date: 5/21/97

20c. Location - City or Town, State: Damascus, Maryland 20872

21. Signature of Funeral Service Licensee: Robert L. Williams

22. Name and Address of Facility: Olin L. Molesworth, P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Brain herniation

Due to (or as a consequence of):

b. large non hemorrhagic — 36 hrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. left hemisphere infarction

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Ø

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death *(Check only one)*: Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [✓] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Konrad W. Bakker, M.D.

29c. License number: D35322

29d. Date signed *(Month, Day, Year)*: 5/18/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Konrad W. Bakker, M.D. 801 Tollhouse Avenue, Frederick, Maryland 21701

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 19 1997

32. Registrar's Signature: Jean Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17414

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Elizabeth Moore

2. Date of Death (Month, Day, Year): MAY 15 1997

3. Time of Death: 0730AM

4a. Facility Name (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: Gaithersburg

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 220-18-1472

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 19, 1916

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 5417 Old National Pike

10f. Zip Code: 21769

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8

College (1-4or 5+): —

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Waitress

16b. Kind of Business/Industry: Food/ Restaraunt

17. Father's Name (First, Middle, Last): Charles C. Carpenter

18. Mother's Name (First, Middle, Maiden Surname): Mamie MacDonald

19a. Informant's Name/Relationship (Type, Print): M. Libby Moore / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 229 W. Montgomery Ave., Rockville, MD 20850

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Olivet Cemetery

Date: 5/19/97

20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: ▶ Paul P.B. MacKay

22. Name and Address of Facility: Stauffer Funeral Home, 1621 Opossumtown Pike, Frederick, MD 21702

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresi, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction — minutes

Due to (or as a consequence of):

b. Coronary Artery Disease — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Gary W. Langston MD

29c. License number: L17947

29d. Date signed (Month, Day, Year): MAY 15, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GARY W. LANGSTON 9901 MEDICAL CENTER DRIVE, ROCKVILLE MD

State Registrar

31. Date filed (Month, Day, Year): MAY 16 1997

32. Registrar's Signature: ▶ Julia Davidson Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17415

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MELVIN JOSEPH MILLER
2. Date of Death (Month, Day, Year): MAY 19 1997
3. Time of Death: 12:17 AM
4a. Facility Name (If not institution, give street and number): DEVLIN MANOR NURSING HOME
4b. City, Town, or Location of Death: CUMBERLAND
4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 176-14-7929
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAY 29 1921
9. Birthplace (State or Foreign Country): PENNA.

Usual Residence of Decedent

10a. State: PENNA.
10b. County: BEDFORD
10c. City, Town or Location: CLEARVILLE
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: RFD#3 BOX#176
10f. Zip Code: 15535
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW 11
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): PENNA. TURNPIKE COMMISSION
16b. Kind of Business/Industry: LABORER

17. Father's Name (First, Middle, Last): RICHARD R. MILLER
18. Mother's Name (First, Middle, Maiden Surname): TERESA MELINDA MILLER

19a. Informant's Name/Relationship (Type, Print): DAVID W. MILLER SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13025 CANYON ROAD N.E. CUMBERLAND MARYLAND 21502

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): UNION CEMETERY
Date: MAY 21 1997
20c. Location - City or Town, State: CENTERVILLE, PA.

21. Signature of Funeral Service Licensee: Dale L. Merritt
22. Name and Address of Facility: MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CHRONIC OBSTRUCTIVE LUNG DISEASE	10 YRS
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D 14865
29d. Date signed (Month, Day, Year): MAY 19, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. R. BARRERA MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND MARYLAND

State Registrar

31. Date filed (Month, Day, Year): MAY 20 1997
32. Registrar's Signature: Debi Hawker-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

lo mjs

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17416

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: SHIRLEY EILEEN MORRISON
2. Date of Death Month / Day / Yaar: May 18 1997
3. Time of Death: 1:55 P.M.
4a. Facility Name *(If not Institution, give streat end number)*: The Memorial Hospital and Medical Center
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 234-56-5143
6. Sex: 1☐ M 2☒ F
7. Aga *(In yrs. last birthday)*: 60 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: Jan 30, 1937
9. Birthplace *(Stata or Foreign Country)*: WV

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: Allegany
10c. City, Town or Location: Oldtown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: P.O. Box 16-Main St.
10f. Zip Code: 21555
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No — if Yes, Give Yaar or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - Amaricen Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work dona during most of working life. DO NOT use retired)*: Retired
16b. Kind of Business/Industry: Village Dairy

17. Father's Name *(First, Middle, Last)*: Simon Lewis
18. Mother's Name *(First, Middle, Maiden Surneme)*: Verdie (NMN)

19a. Informant's Name/Relationship *(Type, Print)*: Sandy Cowgill-daughter
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: Oldtown, MD 21555

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removat from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Three Churches Cemetery
Date: 05/21
20c. Location - City or Town, State: Three Churches, WV

21. Signature of Funeral Service Licensee: Nicholas J Scarpelli
22. Name and Address of Facility: Scarpelli Funeral Home Cumberland, MD 21502

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused tha daath. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line.

Approximata Interval Between Onset and Death

Immediate Cause (Finat disaasa or condition resulting in death)
a. Chronic obstructive lung disease — 10 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immadiate ceuse. Enter Underlying Cause (Diseasa or injury that initiated events rasulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditiona** contributing to death but not rasulting in the underlying cause given in Part I.: Cor pulmonale

23b. Did tobacco use contributa to the causa of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yas 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Ptace of Death *(Check only one)*: Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Rasidence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of injury - At homa, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Straat and Number or Rurel Routa Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the besis of examination and/or Investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: R Barrera
29c. License number: D 14865
29d. Date signed *(Month, Day, Year)*: MAY 21, 1997

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): Dr. R. Barrera, Memorial Hospital Medical Bldg., Cumberland, Md. 21502

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 22 1997
32. Registrar's Signature: Julia Davidson Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17417

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Thomas Leo Montgomery Sr.

2. Date of Death Month / Day / Year: MAY 16, 1997

3. Time of Death: 1825

4a. Facility Name (If not institution, give street and number): Sacred Heart Hospital

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Alleg.

Funeral Director

5. Social Security Number: 220-10-1227

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 7-21-1913

9. Birthplace (State or Foreign Country): WV.

Usual Residence of Decedent

10a. State: Md.

10b. County: Alleg.

10c. City, Town or Location: Cresaptown

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 13805 Brant Rd.

10f. Zip Code: 21502

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Conductor

16b. Kind of Business/Industry: Railroad

17. Father's Name (First, Middle, Last): Thomas M. Montgomery

18. Mother's Name (First, Middle, Maiden Surname): Beulah Powell

19a. Informant's Name/Relationship (Type, Print): Thomas L. Montgomery Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15322 Coon Club Rd. S.W. Frostburg, Md. 21532

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. Peter's Cemetery

Date: 5-19-97

20c. Location - City or Town, State: Westernport, Md.

21. Signature of Funeral Service Licensee: ▶ Wm H Fredlock

22. Name and Address of Facility: Fredlock Funeral Home 31 Jones St. Piedmont, Wv. 26750

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia — 3 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Cerebrovascular Accident

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Thomas E. Chappell MD

29c. License number: D35135

29d. Date signed (Month, Day, Year): MAY 17, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Thomas E. Chappell MD 912 Seton Dr Cumberland MD 21502

State Registrar

31. Date filed (Month, Day, Year): MAY 21 1997

32. Registrar's Signature: ▶ John Gordon Kendall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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NDS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17418

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Bernard Francis McCusker

2. Date of Death: Month MAY; Day 26; Year 1997

3. Time of Death: 06:20A

4a. Facility Name (If not institution, give street and number): Sacred Heart Hospital

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 217-74-9592

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jul 30, 1921

9. Birthplace (State or Foreign Country): WV

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Allegany

10c. City, Town or Location: Cumberland

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 236 E. Mary Street

10f. Zip Code: 21502

10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): unk; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): None

16b. Kind of Business/Industry: N/A

17. Father's Name (First, Middle, Last): Joseph H. McCusker

18. Mother's Name (First, Middle, Maiden Surname): Flora A. (Wilkins)

19a. Informant's Name/Relationship (Type, Print): Cynthia A. Black-niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 27 Beachwood Drive Cumberland MD 21502

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. Mary's Cemetery

Date: 05/28

20c. Location - City or Town, State: Cumberland, MD

21. Signature of Funeral Service Licensee: ▶ Nicholas J Scarpelli

22. Name and Address of Facility: Scarpelli Funeral Home Cumberland, MD 21502

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. pneumonia	6 weeks
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. chronic aspiration	1 year
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

chronic obstructive pulmonary disease

mental retardation

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Bernard Frenz M.D.

29c. License number: 10 9231

29d. Date signed (Month, Day, Year): MAY 26, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DONALD F. MANGER 11600 Bedford Road N.E. CUMBERLAND MD 21502

State Registrar

31. Date filed (Month, Day, Year): MAY 27 1997

Registrar's Signature: ▶ Jabez Thurston Kendall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17419

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: EMMA L. MACKEY

2. Date of Death — Month: MAY Day: 20, Year: 1997

3. Time of Death: 6:40 PM

4a. Facility Name *(If not institution, give street and number)*: CUMBERLAND NURSING HOME

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 214-05-8339

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 87 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan.17,1910

9. Birthplace *(State or Foreign Country)*: OKLAHOMA

Usual Residence of Decedent

10a. State: MD

10b. County: ALLEGANY

10c. City, Town or Location: CUMBERLAND

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 10 N. LIBERTY STREET

10f. Zip Code: 21502

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): UNKNOWN; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SALES CLERK

16b. Kind of Business/Industry: RETAIL STORE

17. Father's Name *(First, Middle, Last)*: CHARLES LEFEVER ABBOTT

18. Mother's Name *(First, Middle, Maiden Surname)*: ELIZABETH J. SMYTH

19a. Informant's Name/Relationship *(Type, Print)*: BETTY J. TAYLOR / NIECE

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P.O. BOX 272 - RIDGELEY, WV 26753

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, cremetory or other place)*: CUMBERLAND CREMATORY

Date: 5/23/97

20c. Location - City or Town, State: CUMBERLAND, MARYLAND

21. Signature of Funeral Service Licensee: Steve D Upchurch

22. Name and Address of Facility: GEORGE-UPCHURCH FUNERAL HOME, P.A. 202 GREENE STREET, CUMBERLAND, MD 21502

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Probable Aspiration Pneumonia — 1 day

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or es e consequence of):
c.

Due to (or es e consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Sunil Gupta MD

29c. License number: D33280

29d. Date signed *(Month, Day, Year)*: May 23,1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sunil Gupta, M.D. - 624 Kent Ave., Cumberland, MD 21502

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 27 1997

32. Registrar's Signature: John Douglas Kimball

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17420

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Howard Louis Nichols

2. Date of Death Month / Day / Year: May 5 1997

3. Time of Death: 8:00 AM

4a. Facility Name *(If not institution, give street and number)*: 9451 Athol Road

4b. City, Town, or Location of Death: Mardela Springs

4c. County of Death: Wicomico

Funeral Director

5. Social Security Number: 213-22-5227

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 70 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Mar.14 1927

9. Birthplace *(State or Foreign Country)*: Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Wicomico

10c. City, Town or Location: Mardela Springs

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 9451 Athol Road

10f. Zip Code: 21837

10g. Citizen of What Country?: U.S.A

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Reca - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Truck Driver

16b. Kind of Business/Industry: None

17. Father's Name *(First, Middle, Last)*: William Irving Nichols SR.

18. Mother's Name *(First, Middle, Maiden Surname)*: L.Bethina Dashiell

19a. Informant's Name/Relationship *(Type, Print)*: Ellen Rae Nichols (Wife)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9451 Athol Rd.Mardela Springs,Md.21837

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Springhill Mem.Garden

Date: 5/10

20c. Location - City or Town, State: Hebron,Md.

21. Signature of Funeral Service Licensee: Gladys B, Stewart

22. Name and Address of Facility: Stewart Funeral Home 821 West Rd.Salisbury,Md.21801

Physician /Medical Examiner

To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on eech line.

Approximate Intervel Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Small Cell Lung Ca — 11-12 mo

Due to (or as e consequenca of):

b. Prostate Cancer

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in deeth) Last

Due to (or es a consequenca of):

c.

Due to (or as e consequenca ot):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No

24b. Were autopsy findings eveileble prior to completion of cause ot deeth? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical exeminer? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury: M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how Injury occurred

28e. Place ot Injury - At home, tarm, street, tactory, offica building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, dete end plece, end due to the cause(s) and manner as steted. 2 [ ] **Medical Examiner:** On the basis ot examinetion end/or investigation, in my opinion, deeth occurred et the time, dete and pleca, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: Joseph N. Grasso

29c. License number: D 20507

29d. Date signed *(Month, Dey, Year)*: 5/7/97

30. Name and address of person who completed cause ot death (Item 23e) (Type, Print): Joseph N. GRASSO 145 E. CARROLL ST SALISBURY MD

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 07 1997

32. Registrar's Signature: Julia Davidson Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17421

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: FRANK JOEL NEEDLE
2. Date of Death Month / Day / Year: MAY 19 1997
3. Time of Death: 5:58am
4a. Facility Name *(If not institution, give street and number)*: SUBURBAN HOSPITAL
4b. City, Town, or Location of Death: BETHESDA
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 577-54-1327
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 56 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: JULY 03, 1940
9. Birthplace *(State or Foreign Country)*: DC

Usual Residence of Decedent

10a. State: MD
10b. County: MONTGOMERY
10c. City, Town or Location: POTOMAC
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 11611 TOULONE DRIVE
10f. Zip Code: 20854
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No — If Yes, Give Year or Dates: 1959-1963
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*:
16b. Kind of Business/Industry:

17. Father's Name *(First, Middle, Last)*: GILBERT NEEDLE
18. Mother's Name *(First, Middle, Maiden Surname)*: RUTH CONSTANCE KLEIN

19a. Informant's Name/Relationship *(Type, Print)*: SHARON LYNNE NEEDLE/ WIFE
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 11611 TOULONE DRIVE, POTOMAC, MD 20854

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: KING DAVID MEM. GDNS. — Date: 05/21/97
20c. Location - City or Town, State: FALLS CHURCH, VA

21. Signature of Funeral Service Licensee: Frank A Stone
22. Name and Address of Facility: DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CEREBRAL HEMORRHAGE	4 WEEKS
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. HYPERTENSION	5 YEARS
Due to (or as a consequence of):		
	c. SEPSIS	3 WEEKS
Due to (or as a consequence of):		
	d. RESPIRATORY DISTRESS	3 WEEKS

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John Yan MD
29c. License number: D40353
29d. Date signed *(Month, Day, Year)*: MAY 19, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. JAMES YAN 11119 ROCKVILLE PIKE, #320, ROCKVILLE, MD 20852

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 22 1997
32. Registrar's Signature: Julie Davidson-Randall

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17422

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): PAUGH NELLIE A

2. Date of Death (Month, Day, Year): 05 24 1997

3. Time of Death: 09:24 am

4a. Facility Name (If not institution, give street and number): DENNETT ROAD MANOR NURSING HOME

4b. City, Town, or Location of Death: OAKLAND, MD

4c. County of Death: GARRETT

Funeral Director

5. Social Security Number: 216-22-5768

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 72 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Apr. 6 1925

9. Birthplace (State or Foreign Country): W.Va

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Md

10b. County: Garrett

10c. City, Town or Location: Oakland

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 12th St & Mary Dr.

10f. Zip Code: 21550

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elamantary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: Homemaker

17. Father's Name (First, Middle, Last): William N. Evans

18. Mother's Name (First, Middle, Maiden Surname): Velta King

19a. Informant's Name/Relationship (Type, Print): Carl Paugh

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 121 Hardesty Rd. Kitzmiller,Md 21538

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cramatory or other place): Deer Park Cemetery

Date: May 27 97

20c. Location - City or Town, State: Deer Park Md

21. Signature of Funeral Service Licensee: David A. Burdock

22. Name and Address of Facility: David A. Burdock Funeral Home PO Box 523 Kitzmiller,Md 21538

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. STROKE — 1 MONTH

Dua to (or as a consaquence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last:

b. Dua to (or as a consaquence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditiona contributing to death but not resulting in the underlying cause given in Part I.

TYPE II DIABETES

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐ Yas 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be datarmined

28a. Date of Injury (Month, Day Year)

28b. Time of injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To tha best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, In my opinion, daath occurred at the time, data and place, and dua to the cause(s) and mannar stated.

29b. Signature and title of certifier: MD

29c. License number: D33464

29d. Date signed (Month, Day, Year): 5/27/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. ROBERT COUGHLIN EGLON CLINIC PO BOX 8 EGLON WV 26716

State Registrar

31. Date filed (Month, Day, Year): MAY 27 1997

32. Registrar's Signature: Julie Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17423

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Permelia Dadds Nelson
2. Date of Death Month May Day 8, Year 1997
3. Time of Death: 9:08 pm
4a. Facility Name *(If not institution, give street and number)*: Memorial Hospital
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 214-34-7994
6. Sex: 1☐ M 2☐ F XX
7. Age *(In yrs. last birthday)*: 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Nov.6,1917
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: Queen Anne's
10c. City, Town or Location: Centreville
10d. Inside City Limits: 1☐ Yes 2☐ No XX
10e. Street and Number: 128 N. Commerce Street
10f. Zip Code: 21617
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married XX 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No XX If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☐ No XX *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Owner-Manager
16b. Kind of Business/Industry: Packaged Goods

17. Father's Name *(First, Middle, Last)*: James Allison Dadds
18. Mother's Name *(First, Middle, Maiden Surname)*: Annie Pinder

19a. Informant's Name/Relationship *(Type, Print)*: Milton L. Nelson-Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 14571 Fox Chase Circle, Ridgely, Md. 21620

20a. Method of Disposition: 1☒ Burial XX 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Chesterfield Cemetery | Date: May 13,1997
20c. Location - City or Town, State: Centreville, Md.

21. Signature of Funeral Service Licensee: ▶ Chad M. Hellenbeun
22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home 114 W. Water St., Centreville, Md.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic Carcinoma — probable Lung primary Unknown
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: E.coli urosepsis

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☑ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ [signature]
29c. License number: D31466
29d. Date signed *(Month, Day, Year)*: 5/9/97
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 12 1997
32. Registrar's Signature: ▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RKD

97-2746-033
97-111
MELVIN McNEIL

Items: 23a part I and II, 27, 28a-f, per MEO G-748 6/11/97 dh

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17424

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
MELVIN Mc NEIL	MAY	17	1997	6:PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
NEWTON STREET & 52 AVE	BLADENSBURG	PRINCE GEORGES

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
579-54-0269	1 X M 2 ☐ F	55 Yrs.			MAY 3, 1942	WASHINGTON, D.C.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
N/A	N/A	WASHINGTON, D.C.	1 X Yes 2 ☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1343 BARNEBY TERRACE S.E.	20032	UNITED STATES AMERICA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	1 YR.	PRINT PLANT WORKER	GOVT.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
LESTER Mc NEIL	JANIE FLOYD

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
ANN Mc NEIL	1325 5th ST. N.W., W.D.C. 20011

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	HARMONY MEMORIAL PARK	5/24/97	LANDOVER, MD.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: JOHNSON & JENKINS INC. 716 KENNEDY ST. N.W. W.D.C. 20011

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. DROWNING	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

SCHIZOPHRENIA;ATHEROSCLEROTIC CARDIOVASCULAR DIESEASE

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 X Yes 2 ☐ No	1 X Yes 2 ☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 X Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) CREEK

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 ☐ Natural 2 XX Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ ~~Pending~~ investigation 6 ☐ Could not be determined	found 5/17/97	found 6:00 P M	1 ☐ Yes 2 XX No	subject drowned

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
found: in creek	Newton and 52nd. Ave. Bladensburg, P.G. County, Maryland

29a. Certifier (Check only one)
1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 X **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature]	O.C.M.E.	MAY 18, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
HAPPARTS D. KOROL MD. 111 Penn Street, Baltimore, Maryland 2120

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 28 1997	[signature]

DHMH 16 Rev 6/95

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

(1)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 17425

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Doris Elizabeth Newman

2. Date of Death Month / Day / Year: May 16 1997

3. Time of Death: 12:10 PM

4a. Facility Name *(If not institution, give street and number)*: Doctor's Community Hospital

4b. City, Town, or Location of Death: Lanham

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 579-22-0726

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Feb 19, 1917

9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Capitol Heights

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2019 Elmwood Park Drive

10f. Zip Code: 20743

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Charles Walden

18. Mother's Name *(First, Middle, Maiden Surname)*: Iona Walker

19a. Informant's Name/Relationship *(Type, Print)*: Shirley A. Storms - Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2019 Elmwood Park Drive Capitol Heights, MD 20743

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Md.National Memorial Park | Date: 5/19/1997

20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: Henry S. Earl

22. Name and Address of Facility: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville MD 20781

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heert failure. List only one ceuse on eech line.

Approximete Interval Between Onset and Deeth

Immediete Ceuse (Finel diseese or condition resulting in death): e. Acute Myocardial Infarct — 4-6 hrs

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Lest

b. Due to (or es e consequence of):

c. Due to (or es e consequence of):

d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypertension; Recurrent Transient Ischemic Attack; Senile Dementia

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No

26. Plece of Deeth *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpetient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)* | 28b. Time of Injury M | 28c. Injury et Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Phyeician**: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner**: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end pleca, end due to the cause(s) and menner steted.

29b. Signature end title of certifier: Villamor D. Reyes M.D.

29c. License number: D29671

29d. Date signed *(Month, Dey, Year)*: May 16/97

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): Villamor D. Reyes, M.D. 6501 Landover Rd. Cheverly MD 20785

State Registrar

31. Dete filed *(Month, Dey, Year)*: MAY 22 1997

32. Registrar's Signeture: John Anderson Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

NEWMAN, DORIS

cr

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17426

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RUTH NEAL

2. Date of Death Month: MAY Day: 19 Year: 1997 FOUND

3. Time of Death: 02:15 PM FOUND

4a. Facility Name (If not institution, give street and number): 3507 EYRE DRIVE NORTH

4b. City, Town, or Location of Death: UPPER MARLBORO

4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 210 24 7791

6. Sex: 1☐ M 2☐ F XX

7. Age (In yrs. last birthday): 64 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 4, 1932

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10e. State: Maryland | 10b. County: Prince George's | 10c. City, Town or Location: Upper Marlboro | 10d. Inside City Limits: XX 1☐ Yes 2☐ No

10e. Street and Number: 3507 Eyre Dr. N. | 10f. Zip Code: 20772 | 10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married XX Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes XX No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Supervisor

16b. Kind of Business/Industry: FBI

17. Father's Name (First, Middle, Last): Carl F. Close

18. Mother's Name (First, Middle, Maiden Surname): Margaret E. Nee

19e. Informant's Name/Relationship (Type, Print): Lawrence A. Neal Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3354 Sackett Lane Winters Ca. 95694

20e. Method of Disposition: XX 1 Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): May 24, 1997 Cedar Hill Cemetery

20c. Location - City or Town, State: Suitland Maryland

21. Signature of Funeral Service Licensee: Robert E. Evans Pres

22. Name and Address of Facility: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: b. | Due to (or as a consequence of): | c. | Due to (or as a consequence of): | d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably XX Unknown

24e. Was an autopsy performed? 1☐ Yes XX No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? XX 1 Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home XX 5 Residence 6☐ Other (Specify)

27. Manner of Death: XX 1 Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28e. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. XX 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Mario F. Golle Jr. M.D.

29c. License number: DEPUTY MEDICAL EXAMINER D33954

29d. Date signed (Month, Day, Year): MAY 20, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): MARIO F. GOLLE JR M.D 3001 HOSPITAL DRIVE, CHEVERLY MARYLAND 20785

State Registrar

31. Date filed (Month, Day, Year): MAY 23 1997

32. Registrar's Signature: Gladys Marie Randall

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

18

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17427

Physician /Medical Examiner

1. Decedant's Name (First, Middle, Last): George Leonard Neal
2. Dete of Death: Month May Day 25, Yaer 1997
3. Time of Death: 4:00a.m.
4a. Facility Nema (If not institution, giva street and number): St. Mary's Hospital
4b. City, Town, or Location of Deeth: Leonardtown
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 213-16-2747
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 77 Yrs.
If Under 1 Yaar: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Dey, Yeer): Feb 19, 1920
9. Birthpiece (Stete or Foreign Country): Maryland

Usuel Residence of Decedent

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Leonardtown
10d. Inside City Limits: 1☐Yas 2☒No
10e. Street end Number: 42215 Blacksmith Shop Road
10f. Zip Coda: 20650
10g. Citizen of Whet Country?: U.S.A.

11. Maritai Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U,S. Armed Forces? 1☐Yes 2☒No If Yas, Giva Yeer or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specity Cuben, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indien, Bleck, White, etc. Specify: Black

15. Decedent's Education (Specify only highast grade complated): Elementery/Secondery (0-12): 8th Grade; College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Bus Driver
16b. Kind of Business/Industry: County Government

17. Fathar's Nama (First, Middle, Last): Joseph L. Neal
18. Mother's Name (First, Middle, Melden Surneme): Gertrude R. Barnes

19a. Informent's Neme/Reletionship (Type, Print): Joseph B. Neal/Brother
19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 22787 Point Lookout Road, Leonardtown, MD 20650

20a. Method of Disposition: 1☒Buriai 2☐Cremation 3☐Removal from State 4☐Donetion 5☐Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Our Lady's Cemetery
Data: 5/29/97
20c. Location - City or Town, Steta: Leonardtown, Maryland

21. Signature of Funeral Service Licensee: Michael L. Gardiner
22. Name end Address of Facility: Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Part1. Enter tha diseese, or complications thet caused the deeth. Do not entar tha mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on aech line.

		Approximeta intervel Between Onset end Deeth
Immediete Ceusa (Finel diseese or condition resulting in death) e.	Hypotension + cardiac arrest	1hr
Due to (or es e consequence of): b.	possible aspiration	1hr
Sequentleily list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in death) Lest. Due to (or es e consequence of): c.	Cachexia + malnutrition	1 mo
Due to (or es e consequence of): d.	Renal + pharyngeal tumors	1 mo

Part ii. **Other significant conditions** contributing to death but not resulting in the underlying cause givan in Part I.

End Stage Renal Disease
Peripheral vascular Disease + Ischemic Necrosis
Insulin Dependent Diabetes mellitus

23b. **Did tobacco use contribute to the cause of death?** 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Wes an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings availeble prior to compiation of cause of death? 1☐Yes 2☐No

25. Wes case referred to medical exeminer? 1☐Yes 2☒No
26. Piece of Deeth (Check only one): Hospitel: 1☒Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Deeth: 1☒Neturei 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined
28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Piece of injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Steta)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end mennar es steted. 2☐**Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) and mennar stated.

29b. Signature and title of certifier: John F. Fenwick
29c. Licensa number: D01380
29d. Date signed (Month, Dey, Yeer): 5-26-97

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print): Dr. John F. Fenwick Leonardtown, MD. 20650

State Registrar

31. Data filed (Month, Day, Yeer): MAY 28 1997
32. Registrar's Signetura: Julie Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME: NEAL, GEORGE LEONARD

DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17428

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ALMEDA E. NEEDY
2. Data of Death Month Day Year: May 22, 1997
3. Time of Death: 4:04 pm
4a. Facility Name (If not institution, give street and number): WASHINGTON COUNTY HOSPITAL
4b. City, Town, or Location of Death: HAGERSTOWN
4c. County of Death: WASHINGTON

Funeral Director

5. Social Security Number: 187-16-4700
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Yaar: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Dey, Yeer): NOV 16, 1915
9. Birthpleca (Steta or Foraign Country): EDGEMONT, MD

Usuel Residence of Decedent

10a. Sfata: MD
10b. County: WASHINGTON
10c. City, Town or Location: HAGERSTOWN
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1116 MT AETNA RD
10f. Zip Code: 21740
10g. Citizen of Whet Country?: USA

11. Meritel Sfatus: 1☐ Navar Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Defes:
13. Was Decedent of Hispenic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - American Indien, Bleck, White, etc. Specify: WHITE

15. Decedent's Educetion (Specify only highest greda completed): Elementery/Secondary (0-12): 6 | College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): OWNER/OPERATOR
16b. Kind of Businass/Industry: TAVERN

17. Fathar's Neme (First, Middle, Last): WALTER SCHILDT
18. Mother's Neme (First, Middle, Meiden Surnama): LEAH SNYDER

19a. Informent's Neme/Reletionship (Type, Print): JOYCE A. REEDER
19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code): 12634 PLEASANT VALLEY RD, SMITHSBURG, MD 21783

20a. Method of Disposition: 1☒ Burial 2☐ Cremefion 3☒ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): GREEN HILL CEMETERY
Dete: 5/27
20c. Location - City or Town, Stete: WAYNESBORO PA 17268

21. Signature of Funeral Service Licensee: James A. Bowersox
JAMES A. BOWERSOX
22. Neme end Address of Facility: GROVE FUNERAL HOME, INC.
50 S BROAD ST WAYNESBORO PA 17268

Physician /Medical Examiner

23a. Pert1. Enter the diseasa, or complications that ceused tha death. Do not enter tha mode of dying, such es cerdiec or respirafory arrest, shock, or heert failure. List only one cause on eech line.

		Approximate Interval Between Onset end Death
Immediate Ceuse (Finel diseese or condition resulting in deeth) e.	Septic Shock	8 hr
Due to (or as e consequence of): b.	Alcoholic liver Disease	20y
Sequentially list conditions, if any, leeding to immediete ceuse. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest — Due to (or es e consequence of): c.	Diverticulosis	20y
Due to (or as a consequence of): d.	Diabetes mellitus, type II	20y

Part It. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings available prior to compleflon of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medicel examiner? 1☐ Yes 2☒ No
26. Piece of Deeth (Check only one): Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28e. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2☐ **Medicat Examiner:** On the basis of examinetion and/or tnvestigetion, In my optnion, deeth occurred et the time, dete end piece, end due to the cause(s) end manner steted.

29b. Signature and title of certifier: Stephen S. Lippman, MD
29c. Licensa number: D35547
29d. Dete signed (Month, Dey, Yeer): May 22, 1997

30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print): STEPHEN S. LIPPMAN 11110 MEDICAL CAMPUS RD HAGERSTOWN MD 21740

State Registrar

31. Dete filed (Month, Dey, Yeer): MAY 23 1997
32. Registrer's Signeture: Julie Davidson Bartlett

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Needy, Almeda Ella

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17429

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Guy Eugene NUSZ,Jr.

2. Date of Death (Month, Day, Year): May 18, 1997

3. Time of Death: 0600

4a. Facility Name (If not institution, give street and number): 8905 Yellow Springs Road

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 219-07-5399

6. Sex: 1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 9, 1919

9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decadant

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 8905 Yellow Springs Road

10f. Zip Code: 21702

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter-Maintenance

16b. Kind of Business/Industry: Park Service

17. Father's Name (First, Middle, Last): Guy Eugene Nusz, Sr.

18. Mother's Name (First, Middle, Melden Surname): Nellie Mary Crabbs

19a. Informant's Name/Relationship (Type, Print): Florence M. Nusz/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8905 Yellow Springs Rd., Frederick, Md. 21702

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Smithsburg Crematory

Date: May 19, 1997

20c. Location - City or Town, State: Smithsburg, Md.

21. Signature of Funeral Service Licensee: ▶ Richard C. C. Basford MD0021

22. Name and Address of Facility: Keeney & Basford Funeral Home, 106 East Church Street, Frederick, Md. 21701

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Ventricular Arrhythmia — minutes

Due to (or as a consequence of):

b. Coronary Artery Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Alzheimers disease

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Allen J. Gibson MD

29c. License number: D26516

29d. Date signed (Month, Day, Year): MAY 19 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ALLEN J. GIBSON MD 1475 TANEY AVE FREDERICK MD 21702

State Registrar

31. Date filed (Month, Day, Year): MAY 20 1997

32. Registrar's Signature: ▶ Linda Davidson Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 17430

Certificate of Death Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: SYLVIA OBERLANDER
2. Date of Death Month / Day / Year: May 19, 1997
3. Time of Death: 8:30
4a. Facility Name *(If not institution, give street and number)*: 9210 Chanute Dr.
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 216-40-5668
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Nov 25, 1911
9. Birthplace *(State or Foreign Country)*: Rhode Island

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 9210 Chanute Drive
10f. Zip Code: 20814
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorcad
12. Wes Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: George Henry Waterhouse
18. Mother's Name *(First, Middle, Maiden Surname)*: Elizabeth Pinkney

19a. Informant's Name/Relationship *(Type, Print)*: Robert George Oberlander -Sr.
19b. Mailing Address *(Straet and Number or Rural Route Number, City or Town, State, Zip Code)*: 3505 East-West Hwy. Chevy Chase MD 20815

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☒ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Union Cemetery
Date: 5/24
20c. Location - City or Town, State: Stratford,CT

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Edward Sagel Funeral Direction 1091 Rockville Pike Rockville MD 20852

To Be Completed by Funeral Director

JW Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or head failure. List only one cause on each line.

Approximete Interval Between Onset end Deeth

Immediate Cause (Final disease or condition resulting In death)
a. CARDIAC AAREST

Due to (or as a consequenca of):
b. ATHEROSCLEROTIC CARDIO YASCULAR DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In deeth) Last
Due to (or as e consequence of):
c.

Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
MULTIINFARCT DEMENTIA

23b. **Did tobacco uee contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings availeble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residenca 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Placa of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature], MD
29c. License number: D26571
29d. Date signed *(Month, Day, Year)*: 5/19/97
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): IRVING MIZUS, MD 4930 DELRAY AVE BETHESDA, MD 20814

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 23 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17431

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Norma Alice O'Gara
2. Date of Death Month Day Year: May 10, 1997
3. Time of Death: 5:45 PM
4a. Facility Name *(If not institution, give street and number)*: St. Catherines Nursing Center
4b. City, Town, or Location of Death: Emmittsburg
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 035-16-2576
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 75 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: Sep. 12, 1921
9. Birthplace *(State or Foraign Country)*: Missouri

Usual Residenca of Decedant

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1☐ Yes 2☐ No
10e. Street and Number: 2359 Bear Den Rd.
10f. Zip Code: 21701
10g. Citizen of What Country?: USA
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowad 4☐ Divorcad
12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): — College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Volunteer Coordinator
16b. Kind of Business/Industry: International Red Cross
17. Father's Name *(First, Middle, Last)*: Charles Gordon Bright
18. Mother's Name *(First, Middle, Maiden Surname)*: Aurora Marie Demers
19a. Informant's Name/Relationship *(Type, Print)*: Diane Brumme, daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2359 Bear Den Rd., Frederick, MD 21701
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Ramoval from State 4☐ Donation 5☐ Other *(Specify)*
20b. Placa of Disposition *(Name of cemetery, crematory or other place)*: Hagerstown Crematory
Date: 5/13/97
20c. Location - City or Town, Stata: Hagerstown, Maryland
21. Signature of Funeral Sarvice Licansee: Raymond Peterson
22. Name and Address of Facility: Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not entar tha moda of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immadiate Cause (Finai disaasa or condition resulting in death)
a. Hepatocellular Cancer — Approximate Interval Between Onset and Death: one yr
Due to (or asa consequence of):
b. with Metastases
Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last
Due to (or as a consequance of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic Alcoholic Cirrhosis with Ascites

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Placa of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At homa, farm, street, factory, office building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*
29a. Certifier *(Check only one)*: 1☒ **Certifying Phyaician:** To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the tima, date and place, and due to tha cause(s) and menner stated.
29b. Signatura and titia of certifier: Ella Cavalli MD
29c. License number: D18705
29d. Data signed *(Month, Day, Year)*: 5/12/97
30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print): 310 S. Seton Ave., Emmitsburg Md.

State Registrar

31. Dete filed *(Month, Day, Year)*: MAY 14 1997
32. Registrar's Signature: John Davidson Randall

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene — *Certificate of Death*

Reg. No. 97 17432

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DESSIE B. ORR

2. Date of Death — Month: MAY Day: 17, Year: 1997

3. Time of Death: 4:10 PM

4a. Facility Name (If not institution, give street and number): SAINT JOSEPH MEDICAL CENTER

4b. City, Town, or Location of Death: TOWSON, MARYLAND

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 242-36-4014

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 74 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 1/19/1923

9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Whiteford

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2520 Whiteford Road

10f. Zip Code: 21160

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 4 College (1-4or 5+):

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own home

17. Father's Name (First, Middle, Last): William Burchette

18. Mother's Name (First, Middle, Maiden Surname): Mary Handy

19a. Informant's Name/Relationship (Type, Print): Mary W. Bostic

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1502 Dooley Road, Whiteford, MD 21160

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Slate Ridge Cemetery Date: 5/20

20c. Location - City or Town, State: Delta, PA

21. Signature of Funeral Service Licensee: Jeffrey P. Lovelace

22. Name and Address of Facility: Harkins Funeral Home, Inc., Delta, PA

Physician /Medical Examiner

23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	RIGHT LEG GANGRENE	SEVERAL DAYS
Due to (or as a consequence of):	MITRAL VALVE REPLACEMENT AND CORONARY ARTERY BYPASS GRAFT	4 DAYS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of):	RUPTURED PAPILLARY MUSCLE	6 DAYS
c. Due to (or as a consequence of):	MYOCARDIAL INFARCTION	10 DAYS
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ACUTE RENAL FAILURE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Timothy Low, M.D.

29c. License number: D24034

29d. Date Signed (Month, Day, Year): 5/17/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): TIMOTHY LOW, M.D., 7620 YORK ROAD, TOWSON, MARYLAND 21204

State Registrar

31. Date filed (Month, Day, Year): MAY 19 1997

32. Registrar's Signature:

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17433

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Joseph Mitchell Owens
2. Date of Death Month / Day / Year: May 16, 1997
3. Time of Death: 6:35 AM
4a. Facility Name *(If not institution, give street and number)*: 25160 Three Notch Road
4b. City, Town, or Location of Death: Hollywood
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 579-18-2895
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jul 24, 1922
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Hollywood
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 25160 Three Notch Road
10f. Zip Code: 20636
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th Grade | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Maintenance Engineer
16b. Kind of Business/Industry: Catalog Distributor

17. Father's Name *(First, Middle, Last)*: William Edward Owens
18. Mother's Name *(First, Middle, Maiden Surname)*: Essie Eulalia Downs

19a. Informant's Name/Relationship *(Type, Print)*: Virginia O. Woods/Sister
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 25160 Three Notch Rd., Hollywood, MD 20636

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Southern Memorial Park
Date: 5/20/97
20c. Location - City or Town, State: North Miami, FL

21. Signature of Funeral Service Licensee: Michael K. Gardiner
22. Name and Address of Facility: Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic Cancer of the Lung — >1yr

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. —

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: David C. Allen M.D.
29c. License number: D25230
29d. Date signed *(Month, Day, Year)*: 5/17/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David Allen, M.D. California, MD 20619

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 19 1997
32. Registrar's Signature: Julia Davidson-Randall

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17434

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: LOUISE PEYTON OLIVE

2. Date of Death Month / Day / Year: MAY 22 1997

3. Time of Death: 4:37 P.M.

4a. Facility Name *(If not institution, give street and number)*: MALCOLM GROW MEDICAL CENTER

4b. City, Town, or Location of Death: CAMP SPRINGS

4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 215-16-4873

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan. 1, 1920

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residance of Decedant

10a. State: Maryland | 10b. County: Prince George's | 10c. City, Town or Location: Ft. Washington | 10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 401 Kerby Parkway | 10f. Zip Coda: 20744 | 10g. Citizan of What Country?: USA

11. Marital Status: 1☐ Navar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Dacadent Ever in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1☐ Yas 2☒ No *Specify:*

14. Race - American Indian, Black, White, atc. *Specify:* White

15. Decedent's Education *(Specify only highast grade compiated)*: Elementery/Secondery (0-12): 12 | College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retired)*: Library Technician

16b. Kind of Businass/Industry: US Government

17. Fathar's Name *(First, Middle, Last)*: Charles A. Peyton

18. Mothar's Nama *(First, Middle, Maidan Surname)*: Mary Edna Jones

19a. Informant's Name/Ralationship *(Type, Print)*: Michael Olive - Son

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 7032 Evergreen Drive, Waldorf, MD 20601

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Placa of Disposition *(Nama of cematary, cramatory or othar place)*: Arlington National Cem. | Data: 5-29-97

20c. Location - City or Town, Stata: Arlington, VA

21. Signature of Funaral Service Licensee: Shannon Ramirez M00798

22. Name and Address of Facility: Huntt Funeral Home, Inc. P. O. Box 156, Waldorf, MD 20604-0156

Physician /Medical Examiner

23a. Part1. Enter tha disaase, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory errest, shock, or haart failura. List only ona causa on aach lina.

Approximate Intarval Batwaan Onsat and Death

Immediata Causa (Final disaasa or condition resulting in death)
e. CARDIOPULMONARY ARREST — 5 YRS

Dua to (or as a consequence of):
DUE TO IDIOPATHIC PULMONARY FIBROSIS

Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaase or Injury thet initiated avents rasulting in death) Last
b. Dua to (or as a consequence of):
c. Dua to (or as a consequanca of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yas 2☒ No

25. Was case referrad to madical examinar? 1☐ Yas 2☒ No

26. Place of Daath *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Othar: 4☐ Nursing Homa 5☐ Rasidanca 6☐ Othar *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding investigation 6☐ Could not be determined

28a. Data of Injury *(Month, Day Year)* | 28b. Tima of Injury | 28c. Injury at Work? 1☐ Yas 2☐ No | 28d. Describe how injury occurred

28a. Placa of Injury - At homa, farm, street, factory, office building, atc. *(Spacify)* | 28f. Location *(Straat and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: ☒ **Certifying Phyaician:** To tha best of my knowladga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. ☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to the ceuse(s) and mannar stated.

29b. Signature and Title of certifiar: [signature]

29c. License number: D42465

29d. Date signed *(Month, Day, Year)*: MAY 22 1997

30. Nama and address of person who completad cause of daath (Item 23e) (Type, Print): WILLIAM C SAWAY,MAJ,USAF,MC — 1050 W PERIMETER RD ANDREWS AFB MD 20762-6600

State Registrar

31. Data filed *(Month, Day, Year)*: MAY 27 1997

32. Registrar's Signatura: Julie Strickler Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17435

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Laura Oden

2. Date of Death: Month May Day 19 Year 1997

3. Time of Death: 702 PM

4a. Facility Name (If not institution, give street and number): Laurel Regional Hospital

4b. City, Town, or Location of Death: Laurel

4c. County of Death: Prince George

Funeral Director

5. Social Security Number: 212-24-2692

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept 13, 1918

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 12221 Cherry Hill Road

10f. Zip Code: 20904

10g. Citizan of What Country?: USA

11. Marital Status: 1☐ Naver Married 2☐ Married 3☒ Widowed 4☐ Divorcad

12. Was Decedant Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grada completed)

Elamantary/Secondary (0-12): Grade 5

Collaga (1-4or 5+):

18a. Dacedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: Own Home

17. Fathar's Nama (First, Middle, Last): unknown Frazier

18. Mothar's Name (First, Middle, Maidan Surname): unknown

19a. Informant's Name/Relationship (Type, Print): Jackie Redmiles granddaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12 Sharon Court #101, Laurel, Maryland 20707

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Nama of cemetery, crematory or other place): Maryland Veterans Cem.

Date: 5/27/97

20c. Location - City or Town, State: Cheltenham, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Nama and Address of Facility: Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389

Physician /Medical Examiner

23a. Part1. Enter tha diseasa, or complications that causad tha daath. Do not antar the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line.

Approximata Interval Between Onsat and Death

Immediata Cause (Final disease or condition resulting in death): a. Cerebrovascular Accident — minutes

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immadiata ceusa. Enter Underlying Cause (Diseasa or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequance of):

d.

Part ii. **Other signficant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: Diabetes Mellitus - Type II

23b. **Did tobacco use contributa to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was cese referred to medicel examinar? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Homa 5☐ Rasidence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Tima of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Phyaician:** To the bast of my knowledge, death occurred at tha time, date and place, and due to the causa(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurred at tha tima, data and place, and due to the causa(s) and manner stated.

29b. Signature and title of certifier: ▶ William A Warner

29c. License number: D13916

29d. Data signed (Month, Day, Year): May 21, 1997

30. Nama and address of person who completed ceusa of daath (Item 23a) (Type, Print): William A. Warner 321 Prince George St Laurel, MD 20707

State Registrar

31. Date filed (Month, Day, Year): MAY 23 1997

32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that tha death certificata be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

DHMH 16 Rav 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17436

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Bernard Pearson, Sr.

2. Date of Death: Month May Day 12 Year 1997

3. Time of Death: 3:55 p.

4a. Facility Name (If not institution, give street and number): Mercy Medical Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: (City)

Funeral Director

5. Social Security Number: 215-26-0190

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 66 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 25, 1931

9. Birthplace (State or Foreign Country): Wash. DC

Usual Residence of Decedent

10a. State: MD

10b. County: Prince Geo.

10c. City, Town or Location: Laurel

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 11717 S. Laurel Drive

10f. Zip Code: 20708

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No. If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Towing Operator

16b. Kind of Business/Industry: Towing Co.

17. Father's Name (First, Middle, Last): Raymond Pearson, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Bernice Smith

19a. Informant's Name/Relationship (Type, Print): Fannie V. Pearson (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11717 S. Laurel Dr., Laurel, MD 20708

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removet from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Pleca of Disposition (Neme of cemetery, crematory or other place): Md. Nat'l Mem. Park

Date: 5/19

20c. Location - City or Town, State: Laurel, MD

21. Signature of Funeral Service Licensee? Sonja K. Snowden

22. Name and Address of Facility: SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850

To Be Completed by Funeral Director

JW Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis — Days

Due to (or es e consequence of):

b. End Staye Renal Disease — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part tt. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part t.: Insulin Dependent Diabetes

23b. **Did tobacco use contribute to the cause of death?** 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Restdence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, atreet, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 ☒ **Certtfying Phyalcian:** To the best of my knowledge, death occurred at the time, dete end pleca, end due to the cause(s) and manner as stated. 2 ☐ **Medtcal Examiner:** On the basis of examination and/or investigetion, tn my opinion, deeth occurred et the time, dete end place, and due to the cause(s) end manner stated.

29b. Signeture and title of certifier: L. Kates MD

29c. License number: PO 9858

29d. Date signed (Month, Day, Year): May 12, 97

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): L KATES MD Mercy Medical Center, Baltimore, MD

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Division of Vital Records, P.O. Box 68760,

5

State Registrar

31. Dete filed (Month, Day, Yeer): MAY 19 1997

32. Registrer's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17437

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JOSEPH PECORINO
2. Date of Death Month Day Year: MAY 18, 1997
3. Time of Death: 3:15 AM
4a. Facility Name *(If not institution, give street end number)*: CARE MATRIX NURSING HOME
4b. City, Town, or Location of Death: SILVER SPRING
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 116-05-7245
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 76 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Oct. 12, 1920
9. Birthplace *(State or Foreign Country)*: New York

Usuel Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Germantown
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street end Number: 20012 Sweetgum Circle
10f. Zip Code: 20874
10g. Citizen of Whet Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forcas? 1 [X] Yas 2 [ ] No If Yes, Giva Year or Dates: 1/43-1/46
13. Was Dacedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - Americen Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elemantary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Milkman
16b. Kind of Business/Industry: Milk Industry
17. Father's Name *(First, Middle, Last)*: Steven Pecorino
18. Mother's Name *(First, Middle, Meiden Surneme)*: Jenni Bocci
19a. Informant's Name/Reletionship *(Type, Print)*: Anne Pecorino (wife)
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 20012 Sweetgum Circle, Germantown, MD 20874
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Piece of Disposition *(Nema of cemetery, cremetory or other piece)*: Quantico National Cem. Data: 5/21 1997
20c. Location - City or Town, State: Triangle, Virginia
21. Signature of Funeral Service Licensee: Gary M. Sunderland
22. Name and Address of Facility: DeVol Funeral Home 10 East Deer Park Drive, Gaithersburg, MD 20877

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the daath. Do not entar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causa on each line.

		Approximata Intervel Between Onset end Death
Immediate Causa (Final diseasa or condition resulting in death) e.	Aspiration Pneumonia	10 days
Due to (or as a consequence of):		
Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Last b.	Congestive Heart Failure	4 months
Due to (or as e consequence of):		
c.		
Due to (or as e consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobecco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes an eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was cese referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 8 [ ] Other *(Specify)*

27. Manner of Deeth: 1 [X] Neturel 2 [ ] Accident 3 [ ] Sulcide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete and piece, and due to the ceuse(s) end menner as stated. 2 [ ] **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end piece, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: Bennett Morrison MD
29c. Licanse number: D 47682
29d. Data signed *(Month, Dey, Year)*: May 19, 1997

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Bennett Morrison 2901 Olney-Sandy Spring Rd Olney Maryland 20832

State Registrar

31. Data filed *(Month, Day, Year)*: MAY 21 1997
32. Registrar's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Maryland Department of Health and Mentel Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 17438

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dina Perchick
2. Date of Death Month, Day, Year: May 17, 1997
3. Time of Death: 7:15pm
4a. Facility Name (If not institution, give street and number): Mariner Health Care of Silver Spring
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 219-64-4361
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 95 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 15, 1902
9. Birthplace (State or Foreign Country): Poland

Usual Residence of Decedent

10a. State: Md.
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1111 University Blvd. Apt. #519
10f. Zip Code: 20902
10g. Citizen of What Country?: US

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Owner
16b. Kind of Business/Industry: Liquor Store

17. Father's Name (First, Middle, Last): Mendel Wolf
18. Mother's Name (First, Middle, Maiden Surname): Chaibasa Ivrey

19a. Informant's Name/Relationship (Type, Print): Shirley Schechter/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 857 Loxford Terrace Silver Spring, Md. 20901

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Beth Sholom Cemetery | Date: 5/19/97
20c. Location - City or Town, State: Wash. DC

21. Signature of Funeral Service Licensee
22. Name and Address of Facility: Edward Sagel Funeral Direction 1091 Rockville Pike Rockville, Md. 20852

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): e. acute myocardial infarction — Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. — Due to (or as a consequence of):
c. — Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: severe dementia

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and Title of certifier: ▶ Sol Rosenbaum
29c. License number: D098734
29d. Date signed (Month, Day, Year): 5/21/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BARRY ROSENBAUM 3720 FARRAGUT AVE. KENSINGTON MD 20895

State Registrar

31. Date filed (Month, Day, Year): MAY 23 1997
32. Registrar's Signature: ▶ Julia Davidson-Randall

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17439

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROSE PERMUT
2. Date of Death (Month, Day, Year): MAY 9, 1997
3. Time of Death: 8:17 PM
4a. Facility Name (If not institution, give street and number): MONTGOMERY GENERAL HOSPITAL
4b. City, Town, or Location of Death: OLNEY
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 578-40-9651
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MARCH 2, 1908
9. Birthplace (State or Foreign Country): WASHINGTON, DC

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: MONTGOMERY
10c. City, Town or Location: SILVER SPRING
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3701 INTERNATIONAL DRIVE #605
10f. Zip Code: 20906
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SECRETARY
16b. Kind of Business/Industry: UNITED STATES GOVERNMENT

17. Father's Name (First, Middle, Last): LOUIS KLABEN
18. Mother's Name (First, Middle, Maiden Surname): IDA (UNKNOWN)

19a. Informant's Name/Relationship (Type, Print): JACOB PERMUT (HUSBAND)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3701 INTERNATIONAL DRIVE #605-SILVER SPRING, MD. 20906

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): JUDEAN MEMORIAL GARDENS
Date: 5/12/97
20c. Location - City or Town, State: OLNEY, MARYLAND

21. Signature of Funeral Service Licensee: Frank A Stone
22. Name and Address of Facility: DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE - ROCKVILLE, MARYLAND 20852

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. METASTATIC COLON CARCINOMA — 2 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Victor Priego MD
29c. License number: D39190
29d. Date signed (Month, Day, Year): MAY 12, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): VICTOR M. PRIEGO, M.D. - 6410 ROCKLEDGE DRIVE #625 - BETHESDA, MARYLAND 20817

State Registrar

31. Date filed (Month, Day, Year): MAY 19 1997
32. Registrar's Signature: Gina Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17440

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jack A. Pruitt

2. Date of Death: Month: May; Day: 17; Year: 1997

3. Time of Death: 3:50 am

4a. Facility Name (If not institution, give street and number): Salisbury Center Genesis ElderCare

4b. City, Town, or Location of Death: Salisbury

4c. County of Death: Wicomico

Funeral Director

218-2

5. Social Security Number: 218-20-7134

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 31, 1926

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: Wicomico

10c. City, Town or Location: Hebron

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 205 E. Church St.

10f. Zip Code: 21830

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Police Officer

16b. Kind of Business/Industry: State & City

17. Father's Name (First, Middle, Last): Alton W. Pruitt

18. Mother's Name (First, Middle, Maiden Surname): India Moore

19a. Informant's Name/Relationship (Type, Print): Jean Forbes

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7213 Opal Circle, Hebron, Md. 21830

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Springhill Memory Gdn.

Date: 5/19/97

20c. Location - City or Town, State: Hebron, Md. 21830

21. Signature of Funeral Service Licensee: Gerald C Bounds

22. Name and Address of Facility: Bounds Funeral Home, Salisbury, Md. 21804

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Metastatic lung cancer — mo.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: 029749

29d. Date signed (Month, Day, Year): 5/18/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): William Robins, M.D. 1104 Healthway Dr., Salisbury, MD 21804

State Registrar

31. Date filed (Month, Day, Year): MAY 20 1997

32. Registrar's Signature: Julia Davidson Randall

DHMH 16 Rev 6/95

97 17441

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LEONARD C. POWELL			2. DATE OF DEATH: MONTH MAY DAY 19 YEAR 1997	3. TIME OF DEATH: 0828 M
4. SOCIAL SECURITY NUMBER: 219-36-7063	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 56 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year): FEB. 10, 1941	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): ATLANTIC GENERAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: BERLIN	9c. COUNTY OF DEATH: WORCESTER	
RESIDENCE OF DECEDENT				
10a. STATE: MARYLAND	10b. COUNTY: WORCESTER	10c. CITY, TOWN OR LOCATION: BERLIN	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO	
10e. STREET AND NUMBER: 10428 DINGES ROAD		10f. ZIP CODE: 21811	10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: 1958-62	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11 College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): WALL PAPER HANGER	16b. KIND OF BUSINESS/INDUSTRY: MAINTENANCE		
17. FATHER'S NAME (First, Middle, Last): LEONARD C. POWELL SR.		18. MOTHER'S NAME (First, Middle, Maiden Surname): LILLIAN BOWERS		
19a. INFORMANT'S NAME (Type/Print): BARBARA A. POWELL/WIFE		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10428 DINGES ROAD, BERLIN, MARYLAND 21811		
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): SALISBURY CREMATORY	DATE: 5/19/97	20c. LOCATION — City or Town, State: SALISBURY, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Charles W Hurst		22. NAME AND ADDRESS OF FACILITY: HASTINGS FUNERAL HOME, SELBYVILLE, DE. 1997		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Hyperkalemia	1-2 hrs.
DUE TO (OR AS A CONSEQUENCE OF): b.	Chronic Renal Failure	6 yrs.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.	Polycystic Kidney Disease	15 yrs.
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Hypertension

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [✓] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [✓] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [✓] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 26b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 28d. DESCRIBE HOW INJURY OCCURED	
	26a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [✓] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Benito S. Chan MD	29c. LICENSE NUMBER: D-20032	29d. DATE SIGNED (Month, Day, Year): 5/19/97

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): BENITO S. CHAN 577-D Riverside Dr. Salisbury, MD 21801

31. DATE FILED (Month, Day, Year): MAY 20 1997	32. REGISTRAR'S SIGNATURE: Julia Davidson Randall

IVA 5

OHMH-16 Rev 1/89

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17442

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Cora Mae Parks
2. Date of Death (Month, Day, Year): May 15, 1997
3. Time of Death: 11:45 PM
4a. Facility Name (If not institution, give street and number): Salisbury Center: Genesis ElderCare
4b. City, Town, or Location of Death: Salisbury, MD
4c. County of Death: Wicomico

Funeral Director

5. Social Security Number: 222-18-5244
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 92 Yrs.
If Under 1 Yaer: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 8, 1904
9. Birthplace (State or Foreign Country): Va.

Usual Residence of Decedent

10a. State: Md.
10b. County: Wicomico
10c. City, Town or Location: Salisbury
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 31740 Kenilworth Dr.
10f. Zip Code: 21801
10g. Citizen of What Country?: USA
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Seamstress
16b. Kind of Business/Industry: Garment Co.
17. Father's Name (First, Middle, Last): James Alvin Bell
18. Mother's Name (First, Middle, Maiden Surname): Julia Dillard Bell
19a. Informant's Name/Relationship (Type, Print): Geraldine P. Mason, Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 31740 Kenilworth Dr. Salisbury, Md. 21801
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Springhill Memory Gardens
Date: 5-20
20c. Location - City or Town, State: Hebron, Md.
21. Signature of Funeral Service Licensee: William M. Short
22. Name and Address of Facility: Short Funeral Home, Inc. 13 E. Grove St. Delmar, De. 19940

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-i show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To Be Completed by Physician/Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not anter tha mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
Immediate Ceuse (Finel disease or condition resulting in death) a.	Coronary artery Disease	yrs
Due to (or as a consequence of): b.	Congestive Heart failure	yrs
Sequentially list conditions, if any, leading to immediate ceusa. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or es e consequence of): c.	Diabetes	yrs
Due to (or es e consequence of): d.	Hypertension	yrs.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performad? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Wes cese referred to medical examiner? 1☐ Yes 2☒ No

28. Piece of Death (Check only one): Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Netural 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, streat, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end manner es steted. 2☐ **Medical Examinar**: On the basis of axamination and/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner stated.

29b. Signeture end title of certifier: William H. Robins
29c. License number: D 29349
29d. Dete signed (Month, Dey, Year): 5/10/97

30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): William H. Robins, M.D. 1104 Healthway Dr., Salisbury, MD 21804

6 Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: Tha law requires that tha death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for usa as the burial-transit

State Registrar

31. Dete filed (Month, Day, Year): MAY 20 1997
32. Registrer's Signeture: Julia Dillard Parker

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17443

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edward L. Pruitt
2. Date of Death (Month, Day, Year): May 28, 1997
3. Time of Death: 6:20 p.m.
4a. Facility Name (If not institution, give street and number): Edw. W. McCready Memorial Hospital
4b. City, Town, or Location of Death: Crisfield
4c. County of Death: Somerset

Funeral Director

5. Social Security Number: 223-26-0771
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 90 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): February 18, 1907
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Virginia
10b. County: Accomack
10c. City, Town or Location: Tangier
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 16383 Main Ridge Road
10f. Zip Code: 23440
10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): Grade 5 — College (1-4or 5+): - - -
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Waterman
16b. Kind of Business/Industry: Seafood

17. Father's Name (First, Middle, Last): Steven Pruitt
18. Mother's Name (First, Middle, Maiden Surname): Evaleen Evans

19a. Informant's Name/Relationship (Type, Print): Velma M. Walter -(Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 308 Decatur Avenue - Salisbury, MD 21804

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Springhill Memory Gardens — Date: 6/2/97
20c. Location - City or Town, State: Hebron, MD

21. Signature of Funeral Service Licensee: Robert H. Bradshaw, Jr.
22. Name and Address of Facility: Bradshaw & Sons Funeral Home, 306 W.Main St.- Crisfield, MD 21817

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Renal Failure
Due to (or as a consequence of): b. Congestive Heart Failure.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last: Due to (or as a consequence of): c.
Due to (or as a consequence of): d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number: D48098
29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Dr. Vijay Kaumbutathar - McCready Hospital, Crisfield, Md. 21817

State Registrar

31. Date filed (Month, Day, Year): JUN - 2 1997
32. Registrar's Signature: Julia Henderson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17444

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Margaret Elizabeth Phillips
2. Dete of Deeth Month / Dey / Yeer: May 10, 1997
3. Time of Death: 1:30 PM
4a. Feclity Name *(If not institution, give street and number)*: Vindobona Nursing Home
4b. City, Town, or Location of Deeth: Braddock Heights
4c. County of Deeth: Frederick

Funeral Director

5. Sociel Security Number: 217-30-5915
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 95 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Yeer)*: 1/1/01
9. Birthplece *(State or Foreign Country)*: Maryland

Usuel Residence of Decedent

10a. Stete: Md.
10b. County: Frederick
10c. City, Town or Location: Brunswick
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 4 North Maryland Avenue
10f. Zip Code: 21716
10g. Citizen of Whet Country?: USA
11. Marital Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Bleck, White, etc. *Specify:* White
15. Decedent's Eduction *(Specify only highest grede completed)*: Elementery/Secondary (0-12): 6; College (1-4or 5+):
16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Clerk
16b. Kind of Business/Industry: Store
17. Father's Neme *(First, Middle, Last)*: William Burns Donovan
18. Mother's Name *(First, Middle, Maiden Surname)*: Emma Virginia Virts
19e. Informent's Neme/Reletionship *(Type, Print)*: Charles D. McLane, Sr., Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 609 West Potomac Street, Brunswick, MD 21716
20e. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Hagerstown Crematory
Dete: 5/12
20c. Location - City or Town, State: Hagerstown, MD
21. Signeture of Funerel Service Licensee: Barbara A. Williams — Barbara Williams, Owner
22. Neme end Address of Feclity: John T. Williams Funeral Home, Brunswick, MD 21716

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart feilure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immediete Ceuse (Finel diseese or condition resulting in deeth): e. Dehydration — 1 week

Due to (or es e consequence of): b. Non specific colitis

Sequentielly list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in deeth) Lest

Due to (or es e consequence of): c.

Due to (or es e consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Plece of Deeth *(Check only one)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28e. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physicien**: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end manner es steted. 2☐ **Medical Examiner**: On the basis of examination end/or investigetion, in my opinion, death occurred et the time, dete end plece, and due to the ceuse(s) end menner stated.

29b. Signeture end title of certifier: [illegible] MD

29c. License number: D22037

29d. Dete signed *(Month, Dey, Yeer)*: MAY 12, 1997

30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): 610 NINTH AVE BRUNSWICK, MD

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: MAY 14 1997

32. Registrer's Signeture: [illegible]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

RKD

97-2593-047

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

MARTIN
PIETSCH Items:23a part I,27, per MEO(LHD) G-748 6/12/97 r&b

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 97 17445

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARTIN E. PIETSCH

2. Dete of Death: Month MAY; Dey 11; Year 1997

3. Time of Death: 1:36P.M.

4e. Feclity Neme (If not Institution, give street end number): 10036 BEAVER DAM CREEK ROAD

4b. City, Town, or Location of Death: BERLIN

4c. County of Deeth: WORCESTER

Funeral Director

5. Sociel Security Number: 002-36-0451

6. Sex: 1☒M 2☐F

7. Age (In yrs. lest birthday): 51 Yrs.

If Under 1 Year: Months; Deys

If Under 24 Hrs.: Hours; Min.

8. Dete of Birth (Month, Dey, Year): 4-6-46

9. Birthpleca (State or Foreign Country): NY

Usuel Residence of Decedent

10e. Stete: NY

10b. County: WESTCHESTER

10c. City, Town or Location: N. SALEM

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street end Number: 38 COTTAGE LANE

10f. Zip Code: 10560

10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐Never Merried 2☒Married 3☐Widowed 4☐Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Yeer or Dates:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Rece - American Indien, Bleck, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grede completed)
Elementery/Secondery (0-12): 12
College (1-4or 5+):

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): COMPUTER COORD.

16b. Kind of Business/Industry: EDUCATION

17. Fether's Neme (First, Middle, Last): MARTIN E. PIETSCH

18. Mother's Neme (First, Middle, Maiden Surneme): LYDIA B. HENNEBERG

19e. Informent's Name/Reletionship (Type, Print): ELLEN S. PIETSCH

19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 38 COTTAGE M LANE N. SALEM, NEW YORK 10560

20e. Method of Disposition: 1☐Buriel 2☒Cremetion 3☐Removal from Stete 4☐Donetion 5☐Other (Specify)

20b. Pleca of Disposition (Neme of cemetery, cremetory or other pleca): SALISBURY CREMETORY

Dete: 5-13

20c. Location - City or Town, Stete: SALISBURY, MD.21811

21. Signeture of Funerel Service Licensee: ▶ [signature]

22. Neme end Address of Feclity: BERLIN, MD. 21811
ULLRICH FUNERAL HOME 10902 OCEAN GATEWAY

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Pert I. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immediate Ceuse (Finel disease or condition resulting in death): e. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in death) Lest

b.

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the ceuee of death? 1☐Yee 2☐No 3☐Probebly 4☒Unknown

24e. Wes en eutopsy performed? 1☒Yes 2☐No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1☐Yes 2☐No

25. Wes case referred to medical examiner? 1☒Yes 2☐No

28. Plece of Deeth (Check only one): Hospital: 1☐Inpetient 2☐ER/Outpetient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) SCENE

27. Menner of Death: 1☒Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigetion 6☐Could not be determined

28e. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury et Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2☒ **Medical Exeminer**: On the besis of exemination end/or Investigetion, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) and menner stated.

29b. Signeture end title of certifier: ▶ Dennis J Chute MD

29c. License number: O.C.M.E.

29d. Date signed (Month, Dey, Yeer): MAY 12, 1997

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Dennis J Chute, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Dey, Yeer): MAY 13 1997

32. Registrer's Signeture: ▶ [signature]

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17446

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LOLA E. PETERMAN

2. Date of Death Month: MAY Day: 20 Year: 1997

3. Time of Death: 2112

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 218-20-7727

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 89 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10/01/1907

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: SOMERSET

10c. City, Town or Location: PRINCESS ANNE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 11974 EDGEHILL TERRACE

10f. Zip Code: 21853

10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSEWIFE

16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): ARCH RIGGIN

18. Mother's Name (First, Middle, Maiden Surname): INA LONG

19a. Informant's Name/Relationship (Type, Print): DELSIE BEAUCHAMP/SISTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11094 HENRY RIGGIN ROAD, PRINCESS ANNE, MD. 21853

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): BEECHWOOD CEMETERY

Date: 5/24/97

20c. Location - City or Town, State: PRINCESS ANNE, MD.

21. Signature of Funeral Service Licensee: James R. Hinman M00295

22. Name and Address of Facility: HINMAN FUNERAL HOME 11673 SOMERSET AVE., PRINCESS ANNE, MD. 21853

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. End Stage Emphysema — 5 yrs

Due to (or as a consequence of):

b. Chronic Obstructive Pulmonary Disease — 5 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Arteriosclerotic Cardiovascular Disease
Congestive Heart Failure; Anxiety Disorder. Asthenia

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Gregorio M. Belloso M.D.

29c. License number: D29505

29d. Date signed (Month, Day, Year): 5-22-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): GREGORIO M. BELLOSO, M.D. 5302 CHINABERRY DR., SALISBURY, MD 21801

State Registrar

31. Date filed (Month, Day, Year): MAY 23 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

LOLA R. PETERMAN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17447

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Louis J. Ponto
2. Date of Death — Month: MAY Day: 25 Year: 1997
3. Time of Death: 11:20AM
4a. Facility Name *(If not institution, give street and number)*: SHADY GROVE ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 199 03 0555
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 82 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: SEPT. 27, 1914
9. Birthplace *(State or Foreign Country)*: PENNSYLVANIA

Usual Residence of Decedent

10a. State: MD.
10b. County: MONTGOMERY
10c. City, Town or Location: SILVER SPRING
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 3501 FOREST EDGE DRIVE APT.#2D
10f. Zip Code: 20906
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 — College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: MECHANIC
16b. Kind of Business/Industry: BUS - TRANSPORTATION

17. Father's Name *(First, Middle, Last)*: FRANK PONTO
18. Mother's Name *(First, Middle, Maiden Surname)*: ELIZABETH SZABO

19a. Informant's Name/Relationship *(Type, Print)*: FRANCIS M. PONTO SON
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 19728 OLNEY MILL ROAD, BROOKEVILLE, MD. 20833

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: GATE OF HEAVEN CEMETERY — Date: 5/29/97
20c. Location - City or Town, State: SILVER SPRING, MD.

21. Signature of Funeral Service Licensee: Muriel H. Barber
22. Name and Address of Facility: MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Cardiopulmonary Arrest	8 DAYS
Due to (or as a consequence of): b.	Aspiration Pneumonia	8 DAYS
Sequentially list conditions, if any, leading to *immediate* cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Respiratory failure	2 months
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypertension; Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: I. Berger M.D.
29c. License number: 044157
29d. Date signed *(Month, Day, Year)*: MAY 25, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Isa Berger M.D. 809 Veirs Mill Road, Rockville, Maryland 20851

State Registrar

31. Date filed *(Month, Day, Year)*: JUN 03 1997
32. Registrar's Signature: Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17448

Physician /Medical Examiner

1. Decedant's Neme *(First, Middle, Last)*: MARGARET VIRGINIA PAYNE

2. Dete of Deeth: Month MAY, Dey 27, Year 1997

3. Time of Death: 2:37 A.M.

4a. Facility Neme *(If not institution, give street and number)*: PHYSICIANS MEMORIAL HOSPITAL

4b. City, Town, or Location of Death: LAPLATA

4c. County of Deeth: CHARLES

Funeral Director

5. Social Security Number: 217-12-9329

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 74 Yrs. (If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.)

8. Dete of Birth *(Month, Dey, Yeer)*: MARCH 6, 1923

9. Birthplace *(Stete or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: CHARLES

10c. City, Town or Location: WALDORF

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 2117 GIBBONS COURT

10f. Zip Code: 20602

10g. Citizen of Whet Country?: UNITED STATES

11. Meritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedant's Education *(Specify only highest grede completed)*: Elementary/Secondery (0-12): 3; College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOUSEWIFE

16b. Kind of Business/Industry: OWN HOME

17. Father's Name *(First, Middle, Last)*: CHARLES LEONARD HALSTEAD

18. Mother's Neme *(First, Middle, Maiden Surneme)*: MAUDE VIOLA PAINTER

19a. Informent's Neme/Relationship *(Type, Print)*: JEAN COATES - DAUGHTER

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 9562 KLINE DRIVE, LA PLATA, MARYLAND 20646

20e. Method of Disposition: 1☒ Buriel 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: MARYLAND VETERANS' CEM.

Dete: MAY 30, 1997

20c. Location - City or Town, State: CHELTENHAM, MARYLAND

21. Signature of Funeral Service Licensee: MGB Mark G. Brohawn

MARK G. BROHAWN M00053

22. Neme and Address of Facility: THE HUNTT FUNERAL HOME, INC. P.O.BOX 156, WALDORF, MARYLAND 20604

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

(Margaret Virginia Payne)

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Myocardial Infarction — hours

Due to (or as a consequance of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Pneumonia — days

Due to (or as a consequance of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

? lung cancer

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Monika Lee MD

29c. License number: D-47849

29d. Date signed *(Month, Day, Year)*: 5/27/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Monika Lee, MD

700 Old Line Center, Suite 100 Waldorf, Maryland 20602

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 28 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17449

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Louise Mills Prickett
2. Date of Death Month Day Year: May 21, 1997
3. Time of Death: 5:10 a.m.
4a. Facility Name (If not institution, give street and number): Maplewood Park Place
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-12-0278
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 93 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Apr.12,1904
9. Birthplace (State or Foreign Country): Washington D.C.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8615 Melwood Road
10f. Zip Code: 20817
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary
16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): William D. Mills
18. Mother's Name (First, Middle, Maiden Surname): Bessie Franklin

19a. Interment's Name/Relationship (Type, Print): Mary E. Violett (executrix)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14504 Lightner Road, Haymarket VA 20169

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Rock Hill Cemetery
Date: 1997 24 May
20c. Location - City or Town, State: Stafford County VA

21. Signature of Funeral Service Licensee: Kathleen L. McDonnell
22. Name and Address of Facility: Moser Funeral Home Inc. 233 Broadview Ave Warrenton Virginia 20186

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Aspiration Pneumonia	5 days
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Cerebrovascular accident	1 yr.
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Fractured Femur, Fractured hip 2/97

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Lee R. Pennington, MD
29c. License number: D21115
29d. Date signed (Month, Day, Year): 5/21/97
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Lee R. Pennington MD, 5602 Shallcross Drive, Bethesda, MD 20817

State Registrar

31. Date filed (Month, Day, Year): MAY 23 1997
32. Registrar's Signature: John Davidson Rendall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17450

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: John Ponoski Jr.

2. Date of Death Month May Day 19 Year 1997

3. Time of Death: 4:00 P.M.

4a. Facility Name *(If not institution, give street and number)*: Anne Arundel Medical Center

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 183 18 0817

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 74 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct. 23, 1922

9. Birthplace *(State or Foreign Country)*: Pennsylvania

To Be Completed by Funeral Director

Usual Residance of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Landover Hills

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 3804 72nd Ave.

10f. Zip Code: 20784

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? ☒ Yes 2 ☐ No — If Yes, Give Year or Dates: 42-43

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4 or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Special Police

16b. Kind of Business/Industry: U.S. Government

17. Father's Name *(First, Middle, Last)*: John Ponoski Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Wenzel

19a. Informant's Name/Relationship *(Type, Print)*: Chiara Ponoski Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3804 72nd Ave. Landover Hills Maryland 20784

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Maryland Veterans Cemetery — Date: May 27, 1997

20c. Location - City or Town, State: Cheltenham Md.

21. Signature of Funeral Service Licensee: Michael L Bigler

22. Name and Address of Facility: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Respiratory Failure	3 wks
Due to (or as a consequence of): b.	pneumonia	3 wks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	COPD	5 years
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)* — 28b. Time of Injury — M — 28c. Injury at Work? 1 ☐ Yes 2 ☐ No — 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* — 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: S. Selonick, M.D.

29c. License number: D19838

29d. Date signed *(Month, Day, Year)*: 5/21/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stuart E. Selonick, M.D. 900 Bestgate Rd. Annapolis, Md. 21401

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 23 1997

32. Registrar's Signature: Julie Davidson Parker

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17451

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Janet Kay Perry

2. Date of Death Month Day Year: May 26, 1997

3. Time of Death: 3:48 P.M

4a. Facility Name (If not institution, give street and number): Bayside Nursing Center

4b. City, Town, or Location of Death: Lexington Park

4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 352-56-8996

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 38 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jun 6, 1958

9. Birthplace (State or Foreign Country): Illinois

Usuet Residence of Decedent

10a. Stata: Maryland

10b. County: St. Mary's

10c. City, Town or Location: Lexington Park

10d. Inside City Limits: 1☐ Yas 2☐ No

10e. Street and Number: 21676 Susan Lane Apt. E

10f. Zip Code: 20653

10g. Citizen of Whst Country?: U.S.A.

11. Maritel Status: 1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedant Ever in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Give Yaar or Datas:

13. Wes Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, Whita, atc. Specify: White

15. Decedent's Education (Specify only highest grada completed)

Elamantary/Secondery (0-12):

Collaga (1-4or 5+): 2 years

18a. Decedent's Usuel Occupetion (Give kind of work done during most of working lifa. DO NOT use retired): Homemaker

16b. Kind of Businass/Industry: Own Home

17. Fether's Neme (First, Middla, Last): Harold Eugene Williams

18. Mother's Neme (First, Middle, Meidan Surnema): Nina Bell Allison

19a. Informent's Neme/Reletionship (Type, Print): Tony Lee Perry, Sr./Spouse

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 21676 Susan Lane, Apt. E, Lexington Park, MD 20653

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Name of camatary, crametory or other place): Evergreen Memorial Gardens

Date: 5/29/97

20c. Location - City or Town, Stata: Lexington Park, MD

21. Signature of Funaral Service Licensee: ▶ Michael K. Gardiner

22. Nama and Address of Facility: Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Part1. Enter tha disaase, or complications thet causad the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart feilure. List only one cause on eech line.

Approximete Interval Between Onset and Death

Immediete Cause (Finel disaasa or condition resulting in deeth): a. Metastatic Cancer of Colon — years

Due to (or es a consequence of):

Sequentiatly tist conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Disease or injury thet initieted events rasulting in death) Last:

b. Due to (or es e consequenca of):

c. Due to (or es a consequence of):

d.

Part ff. **Other significant conditions** contributing to death but not resulting in the underlying cause givan in Part i.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yas 2☐ No

25. Was casa rafarred to medical examiner? 1☐ Yas 2☒ No

26. Place of Death (Check only one): Hospitel: 1☐ inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Homa 5☐ Residence 8☐ Othar (Specify)

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, end due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pieca, and due to the cause(s) and mannar stated.

29b. Signeture and title of certifier: ▶ D C A M D

29c. Licensa number: D 25239

29d. Data signed (Month, Day, Year): 5-27-97

30. Neme and address of person who completed cause of death (Item 23e) (Type, Print): David C. Allen, M.D. California, MD 20619

State Registrar

31. Date filed (Month, Day, Year): MAY 28 1997

32. Registrar's Signatura: Judi Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17452

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ELEANOR J. POET Eleanor Janet Poet
2. Date of Death: Month MAY Dey 21 Yaar 1997
3. Time of Death: A.M 01:06 Hr
4a. Facility Neme (If not institution, give street end number): UNIVERSITY OF MARYLAND MEDICAL SYSTEM
4b. City, Town, or Location of Deeth: BALTIMORE
4c. County of Deeth: BALTIMORE

Funeral Director

5. Social Sacurity Number: 011-30-2095
6. Sax: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 58 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yaar): Jan. 20, 1939
9. Birthplace (Stata or Foreign Country): Massachusetts

Usuel Residance of Decadent

10a. Stete: Md.
10b. County: Washington
10c. City, Town or Location: Smithsburg
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 11936 Comanche Dr.
10f. Zip Code: 21783
10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Merriad 3☐ Widowed 4☐ Divorcad
12. Wes Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No — It Yes, Give Yeer or Detas:
13. Was Decedant ot Hispenic Origin? (Specify Yes or No- It Yas, specify Cuben, Mexican, Puerto Ricen, etc.) 1☐ Yes 2☒ No Specify:
14. Reca - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highast grede completed): Elementery/Secondery (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Clerk
16b. Kind of Business/Industry: Store

17. Fathar's Neme (First, Middle, Last): Pearly Toothaker
18. Mother's Neme (First, Middle, Meiden Surneme): Eva Sweeney

19a. Informent's Name/Reletionship (Typa, Print): Robert W. Poet (husband)
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 11936 Comanche Dr. Smithsburg, Md. 21783

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place ot Disposition (Neme of cemetery, cremetory or othar piece): Smithsburg Cemetery
Dete: May 26, 1997
20c. Location - City or Town, Steta: Smithsburg, Md.

21. Signature of Funeral Service Licensee: Dennis L. Davis
22. Neme end Address of Feciility: Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that caused the death. Do not enter the mode ot dying, such es cardiac or raspiretory arrest, shock, or heert tailure. List only one ceuse on eech tine.

		Approximete Interval Between Onset end Death
Immedieta Causa (Finel diseese or condition resulting in deeth) e.	CARDIAC ARREST	30 Minutes
Dua to (or es e consequenca of):		
b.	TACHY - ARRHYTHMIA	5 Hours
Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Last — Due to (or es a consequence of): c.	PULMONARY FAILURE	
Due to (or es e consequence of): d.	SINGLE LUNG (LEFT) TRANSPLANT	14 Days

Part II. **Other signifticant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes an eutopsy performed? 1☒ Yas 2☐ No
24b. Were eutopsy tindings eveileble prior to completion of ceuse of deeth? 1☐ Yes 2☒ No

25. Wes case referred to medical exeminar? 1☐ Yes 2☒ No

26. Place ot Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Homa 5☐ Residence 6☐ Othar (Specify)

27. Menner ot Deeth: 1☒ Neturel 2☐ Accidant 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Dete ot Injury (Month, Dey Yaar): N/A
28b. Time of Injury: N/A M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: N/A
28e. Place of Injury - At home, tarm, street, fectory, office building, etc. (Specify): N/A
28f. Location (Street and Number or Rural Route Number, City or Town, Stete): N/A

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best ot my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner**: On the besis of exemination and/or investigation, in my opinion, daeth occurred et tha time, data and place, end due to the ceuse(s) end menner steted.

29b. Signature end title of certifier: Jaime G. Dorotan MD
29c. Licensa number: R1205
29d. Dete signed (Month, Dey, Yaar): MAY 21, 1997

30. Name end eddress ot person who completed cause of death (Item 23e) (Type, Print): JAIME G. DOROTAN, MD 22 S. Greene St. Baltimore, Md. 21201 UNIVERSITY OF MARYLAND MEDICAL SYSTEM

State Registrar

31. Dete tiled (Month, Dey, Yaar): MAY 23 1997
32. Registrer's Signeture: Julia Davidson Parker

DHMH 16 Rav 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17453

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Sadie Lee Powers

2. Date of Death Month May Day 18 Year 1997

3. Time of Death: 5:08 p.m

4a. Facility Name *(If not institution, give street and number)*: Shady Grove Adventist Nursing Center

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 227-48-1553

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 61 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Aug 22 1935

9. Birthplace *(State or Foreign Country)*: VA

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Dickerson

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 19601 Barnesville Road

10f. Zip Code: 20842

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 7 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: homemaker

16b. Kind of Business/Industry: homemaker

17. Father's Name *(First, Middle, Last)*: Robert F. Monroe

18. Mother's Neme *(First, Middle, Melden Sumeme)*: Mamie B. Monroe

19a. Informant's Name/Relationship *(Type, Print)*: James Williams / son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P.O. Box 164 Thurmont, MD 21788

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Monocacy

Date: 5/21

20c. Location - City or Town, State: Beallsville, MD

21. Signature of Funeral Service Licensee: Wm C Hilton

22. Name end Address of Facility: Hilton Funeral Home Barnesville, MD 20838

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heert feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediete Ceuse (Finel disease or condition resulting in deeth)

a. Hypercalcemia — 1 week

Due to (or es e consequence of):

b. Bone metastasis, diffuse — 3 months

Due to (or as a consequence of):

Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last

c. Liver metastasis — 5 months

Due to (or as e consequence of):

d. Cervical Carcinoma — 10 months

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

Deep Vein Thrombusis

Peripheral Vascular disease

Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner**: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Takao L. Sato MD

29c. License number: D44120

29d. Date signed *(Month, Day, Year)*: May 15, 1997

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Takao L. Sato, MD 9715 Medical Center Dr. St503, Rockville, MD 20850

State Registrar

31. Dete filed *(Month, Dey, Year)*: MAY 23 1997

32. Registrar's Signature: Jacqueline Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17454

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Marjorie Ellen Posey
2. Date of Death Month: MAY Day: 20 Year: 97
3. Time of Death: 2250
4a. Facility Name (If not institution, give street and number): 201 B Street
4b. City, Town, or Location of Death: Lothian
4c. County of Death: AA.

Funeral Director

5. Social Security Number: 578-52-7251
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 56 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 22,1940
9. Birthplace (State or Foreign Country): Washington DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Lothian
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 201 B Street Lyons Creek Mobile Home Estates
10f. Zip Code: 20711
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4 or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Owner/Operator
16b. Kind of Business/Industry: Hair Salon

17. Father's Name (First, Middle, Last): Henry A. McStay
18. Mother's Name (First, Middle, Maiden Surname): Bernice A. Childs

19a. Informant's Name/Relationship (Type, Print): Agnes B. Calub (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1880 Calvert Circle Huntingtown, Maryland 20639

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of Cemetery, crematory, or other place): Lee Crematory / Arlington National Cem. Date: June 3, 1997
20c. Location - City or Town, State: Clinton, Maryland / Arlington, Virginia

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, Md 20735

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Arteriosclerotic Heart Disease	UNK
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? N/A 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Deputy MD
29c. License number: D 060054
29d. Date signed (Month, Day, Year): 5/21/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William P. Jones, MD 695 America 21035

State Registrar

31. Date filed (Month, Day, Year): MAY 27 1997
32. Registrar's Signature: [signature] Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17455

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JACKIE M. PARSONS
2. Date of Death Month / Day / Year: MAY 13 1997
3. Time of Death: 9:59 PM
4a. Facility Name *(If not institution, give street and number)*: 606 MARKET STREET
4b. City, Town, or Location of Death: POCOMOKE
4c. County of Death: WORCESTER

Funeral Director

5. Social Security Number: 220-32-8111
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 59 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: AUG. 14, 1937
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: WORCESTER
10c. City, Town or Location: POCOMOKE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 606 MARKET STREET
10f. Zip Code: 21851
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: CUSTOMER SERVICE REPRESENTATIVE
16b. Kind of Business/Industry: AUTOMOBILE

17. Father's Name *(First, Middle, Last)*: LAWRENCE R. PARSONS
18. Mother's Name *(First, Middle, Maiden Surname)*: BESSIE MARINER

19a. Informant's Name/Relationship *(Type, Print)*: BARBARA L. PARSONS/WIFE
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 606 MARKET STREET, POCOMOKE, MARYLAND 21851

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: FIRST BAPTIST CEMETERY
Date: 5/16/97
20c. Location - City or Town, State: POCOMOKE, MARYLAND

21. Signature of Funeral Service Licensee: Charles W Hastings
22. Name and Address of Facility: HASTINGS FUNERAL HOME, SELBYVILLE, DELAWARE 19975

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Acute Myelogenous Leukemia

Due to (or as a consequence of):
b. Metastatic Disease to Lung

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

Due to (or as a consequence of):
c. Carcinoma of the Larynx

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Helen M. Baldado M.D
29c. License number: D16840
29d. Date signed *(Month, Day, Year)*: 5/15/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): 547-F RIVERSIDE DRIVE, SALISBURY, MD. 21801

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 15 1997
32. Registrar's Signature: Julia Davidson Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17456

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Frank Quinnell

2. Deta of Death: Month May Dey 20, Yeer 1997

3. Time of Death: 11:00 AM

4e. Facility Name (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: Rockville

4c. County of Deeth: Montgomery

Funeral Director

5. Social Security Number: 159-05-2251

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 91 Yrs.

If Under 1 Yaar: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Deta of Birth (Month, Day, Year): Feb. 28, 1906

9. Birthpiece (Steta or Foreign Country): Pennsylvania

Usuel Residance of Decedent

10a. Stata: Maryland

10b. County: Montgomery

10c. City, Town or Location: Gaithersburg

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 211 Russell Avenue, #120

10f. Zip Code: 20877

10g. Citizan of Whet Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armad Forces? 1☐ Yas 2☒ No If Yes, Give Year or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuben, Maxican, Puerto Ricen, etc.) 1☐ Yes 2☒ No Specify:

14. Race - Amarican Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highast grede completed): Elementery/Secondery (0-12) / College (1-4or 5+): 4

18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mechanical Engineer

16b. Kind of Business/Industry: Patents

17. Father's Name (First, Middle, Last): Robert Thomas Quinnell

18. Mother's Name (First, Middle, Meiden Sumame): Annie Elizabeth Reid

19e. Informant's Name/Reletionship (Type, Print): Doris Quinnell Murray/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1281 Bartonshire Way, Rockville, Maryland 20854

20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removal from Steta 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Nema of cemetery, cremetory or othar piece): Northwood Cemetery

Dete: May 23, 1997

20c. Location - City or Town, Steta: Philadelphia, Pennsylvania

21. Signeture of Funerel Service Licensee: Michele P. Lutta M00348

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the moda of dying, such as cerdiac or raspiretory errest, shock, or heart feilura. List only one ceuse on each line.

Approximete Interval Between Onset end Death

Immediete Ceuse (Finel disaesa or condition resulting in daath)

a. Acute Myocardial Infarction — Minutes

Dua to (or es e consequence of):

Sequentially list conditions, if eny, laeding to immediata cause. Enter Underlying Ceusa (Disease or injury thet initieted evants resulting in deeth) Last

b. Arteriosclerotic Heart Disease — Years

Dua to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. Other aignificant conditions contributing to death but not resulting in tha undarlying ceuse given in Part I.

Hypertension

Non Metastatic Prostatic Cancer

23b. Did tobacco uas contribute to the causa of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en autopsy performed? 1☐ Yas 2☒ No

24b. Were eutopsy findings availeble prior to completion of ceuse of daath? 1☐ Yas 2☒ No

25. Was cese refarred to medical examiner? 1☐ Yes 2☒ No

28. Piece of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Othar (Specify)

27. Mennar of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be daterminad

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Dascribe how injury occurred

28e. Piece of injury - At home, ferm, streat, factory, office buiiding, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledga, daath occurred at the time, dete end piece, end due to tha causa(s) end mennar as stated. 2☐ Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, daath occurred et the time, date end place, end due to tha cause(s) end mannar stated.

29b. Signature and title of certifier: Edward Wilson M.D.

29c. License number: D19322

29d. Dete signed (Month, Dey, Year): May 20, 1997

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Edward Wilson 9901 Medical Center Drive Rockville MD

State Registrar

31. Dete filed (Month, Day, Year): MAY 23 1997

32. Registrar's Signature: Jutha Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17457

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Frealin MacAdoo Qualls
2. Date of Death Month / Day / Year: May 14 1997
3. Time of Death: 0635AM
4a. Facility Name *(If not institution, give street and number)*: 1680 Justin Drive
4b. City, Town, or Location of Death: Gambrills
4c. County of Death: A Arundel

Funeral Director

5. Social Security Number: 408 14 7571
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 76 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sept. 18, 1920
9. Birthplace *(State or Foreign Country)*: Tennessee

Usual Residence of Decadant

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Gambrills
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 1680 Justin Drive
10f. Zip Code: 21054
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Evar in U.S. Armed Forcas? ☒ Yes 2 ☐ No — If Yes, Giva Year or Dates: 42-53
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.): 1 ☐ Yes ☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grada completed)*: Elamantary/Secondary (0-12): 12 — College (1-4or 5+): 3
16a. Decedent's Usual Occupation *(Giva kind of work done during most of working life. DO NOT use retired)*: Cryptographer
16b. Kind of Business/Industry: CIA

17. Father's Name *(First, Middle, Last)*: Frealin Qualls
18. Mother's Nama *(First, Middle, Malden Surname)*: Anna MacAdoo

19a. Informent's Name/Reletionship *(Type, Print)*: Jacqueline M. Qualls Wife
19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1680 Justin Drive Gambrills Maryland 21054

20a. Method of Dispoaition: ☒ 1 Burial 2 ☐ Cremetion 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Othar *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or othar place)*: Maryland Veterans Cemetery — Data: 5/19/97
20c. Location - City or Town, Stata: Crownsville Md.

21. Signatura of Funeral Service Licensee: Michael L Dyson
22. Neme and Address of Facility: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or raspiretory errest, shock, or heart failura. List only one causa on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Arteriosclerotic Heart Disease UNK
Due to (or as a consequence of):

Sequantially list conditiona, if any, leading to immadiata causa. Entar Underlying Cause (Disease or injury that initiated events rasulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Diabetes

23b. Did tobacco use contributa to the cause of death? 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was casa referred to medical examiner? 1 ☒ Yas 2 ☐ No
26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Othar *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Tima of Injury
28c. Injury at Work? 1 ☐ Yas 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☐ **Certifying Physician:** To the best of my knowledge, daath occurred at the time, date and place, and dua to the ceusa(s) and menner as atated. 2 ☒ **Medical Examiner:** On the besis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signatura and titie of certifiar: William P. Jones, Deputy MD
29c. Licansa number: D 06054
29d. Date signed *(Month, Day, Year)*: 5/14/97
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William P. Jones MD 695 America 21035

State Registrar

31. Dete filed *(Month, Day, Year)*: MAY 21 1997
32. Registrar's Signature: Julia Gardner Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

40 JVP

97-2631-031
jhm
PATRICIA
REIDINGER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17458

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Patricia Elva Reidinger
2. Date of Death (Month, Day, Year): MAY 13, 1997
3. Time of Death: 02:15AM
4a. Facility Name (If not institution, give street and number): 7925 CHICAGO AVENUE #101
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 171-40-4651
6. Sex: 1☐ M 2☒ F
7. Age (in yrs. last birthday): 48 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 28, 1948
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7925 Chicago Ave. # 101
10f. Zip Code: 20910
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): office manager
16b. Kind of Business/Industry: Real Estate Dev. Co.

17. Father's Name (First, Middle, Last): William Michael Springer
18. Mother's Name (First, Middle, Maiden Surname): Agnes Elva Sheehan

19a. Informant's Name/Relationship (Type, Print): Schuyler Shane Reidinger/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 616 Silver Spring Ave. #3 Silver Spring, MD 20910

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitian Crematory
Date: May 17, 1997
20c. Location - City or Town, State: Alexandria, VA

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Takoma Funeral Home, Inc. 254 Carroll St. NW Washington, DC 20012

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Fatty liver
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and ~~title of certifier~~: [signature]
29c. License number: OCME
29d. Date signed (Month, Day, Year): MAY 13, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David R Fowler 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): MAY 19 1997
32. Registrar's Signature: [signature] Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17459

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Louis L. Rosenthal
2. Data of Death Month Day Year: May 20, 1997
3. Time of Death: 9 pm
4a. Facility Name *(If not institution, giva street and number)*: 19105 Heritage Hills Road
4b. City, Town, or Location of Death: Brookeville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-22-8012
6. Sex: 1 ☒ M 2 ☐ F
7. Aga *(In yrs. last birthday)*: 87 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Year)*: May 19, 1910
9. Birthplece *(State or Foreign Country)*: Wash. DC

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: N. Bethesda
10d. Insida City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 5440 Marinelli Road
10f. Zip Code: 20852
10g. Citizen of What Country?: US

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No — If Yes, Giva Year or Dates:
13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.): 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - Americen Indian, Black, White, etc. *Specify:* White

15. Decedent's Educetion *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Owner/Salesman
16b. Kind of Business/Industry: MensClothing

17. Father's Name *(First, Middla, Last)*: Henry Rosenthal
18. Mother's Name *(First, Middle, Meiden Surname)*: Attie Ashkovitz

19a. Informant's Name/Relationship *(Type, Print)*: Arnold Rosenthal-son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 19105 Hertiage Hills Dr. Brookeville MD 20833

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or othar place)*: King David Memorial — Date: 5/22
20c. Location - City or Town, State: Falls Church, VA

21. Signature of Funaral Service Licensee: ▶ Ed Sagel
22. Name and Address of Facility: Edward Sagel Funeral Dir. 1091 Rockville Pike Rockville MD 20852

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the daath. Do not anter tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

		Approximate Interval Between Onsat and Death
Immediete Cause (Final disease or condition resulting in death) a.	PNEUMONIA	DAYS
Due to (or as a consequence of): b.	BRONCHOGENIC CARCINOMA	6 YRS
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Dua to (or as a consequence of): d.		

Part II. **Other eignificant conditfone** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. **Did tobacco uee contribute to the cauee of death?** 1 ☒ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were eutopsy findings available prior to completion of causa of death? 1 ☐ Yes 2 ☐ No

25. Was cese refarred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Naturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Phyeician:** To the best of my knowledge, deeth occurred at the time, date and piece, and due to the ceuse(s) end menner es steted. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner steted.

29b. Signature and title of certifier: ▶ Steven T. Kariya — MD
29c. License number: D36252
29d. Date signed *(Month, Dey, Year)*: MAY 23, 1997

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print): STEVEN T. KARIYA, MD, 11501 GEORGIA AVE #515 WHEATON MD 20902

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 23 1997
32. Registrar's Signature: ▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requiras that the death certificeta be executed within 24 hours after death.
To the Funeral Director: Aftar this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for usa as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 17460

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: FLORENCE ROTHMAN

2. Data of Death Month: MAY Day: 16 Yaar: 1997

3. Tima of Death: 6:15 AM

4a. Facility Name *(If not institution, give street and number)*: HOLY CROSS HOSPITAL

4b. City, Town, or Location of Deeth: SILVER SPRING

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Numbar: 130-07-4719

6. Sex: 1☐ M 2☒ F

7. Aga *(In yrs. last birthday)*: 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: January 2,1921

9. Birthplaca *(State or Foreign Country)*: New York

Usual Residance of Decedant

10a. Stata: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Insida City Limits: 1☐ Yas 2☒ No

10e. Street end Number: 613 Hyde Rd.

10f. Zip Coda: 20902

10g. Citizen of Whet Country?: United States

11. Marital Stetus: 1☐ Never Married 2☒ Married 3☐ Widowad 4☐ Divorced

12. Wes Dacedant Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yas, Giva Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.): 1☐ Yas 2☒ No *Specify:*

14. Race - American Indian, Black, Whita, atc. *Specify:* White

15. Decedant's Education *(Specify only highest grade completed)*: Elemantary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decadant's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Fethar's Nama *(First, Middle, Last)*: Isidor Rosen

18. Mother's Name *(First, Middle, Maiden Surname)*: Sadie "Unknown"

19a. Informant's Name/Relationship *(Type, Print)*: Sam Rothman (Husband)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 613 Hyde Rd., Silver Spring, MD. 20902

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. Lebanon Cemetery

Data: 5-18-97

20c. Location - City or Town, Steta: Adelphi, Maryland

21. Signatura of Funeral Service Licansee ▶

22. Nama and Address of Facility: DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE - ROCKVILLE, MD. 20852

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused tha daath. Do not antar tha mode of dying, such as cardiac or raspiretory errast, shock, or hart failure. List only ona causa on aach line.

Approximate Intarval Batween Onsat and Death

Immediate Cause (Final disease or condition rasulting in death) a. Catonia — 1 Week

Due to (or as a consaquanca of): Hyponaurmia — 1 Week

Saquantially list conditions, if any, laading to immadiata cause. Enter Undarlying Causa (Disaasa or injury that Initiated avents resulting in daath) Last

b. Dua to (or as a consequance of):

c. Dua to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha undarlying causa givan in Part I.

23b. Did tobacco usa contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performad? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was casa referred to medical examinar? 1☐ Yas 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatiant 3☐ DOA Other: 4☐ Nursing Homa 5☐ Residence 6☐ Othar *(Specify)*

27. Mannar of Daath: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding Invastigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28e. Place of Injury - At homa, farm, straat, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifiar *(Check only one)*: 1☒ **Certifying Phyaician:** To the best of my knowledga, daath occurred at the tima, data and place, and dua to tha cause(s) and manner as stated. 2☐ **Medical Examinar:** On the basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar stated.

29b. Signatura and titla of certifiar ▶ Alan Wenstock MD

29c. Licansa number: D 09748 MD

29d. Data signed *(Month, Day, Year)*: May, 16, 1997

30. Nama and address of parson who completed causa of daath (Item 23a) (Type, Print): 10313 Georgia Ave., Silver Spring, MD 20902

State Registrar

31. Data filed *(Month, Day, Year)*: MAY 19 1997

32. Registrar's Signature: Erika Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17461

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARILYN G. ROWEN
2. Date of Death (Month, Day, Year): MAY 19, 1997
3. Time of Death: 9:00 AM
4a. Facility Name (If not institution, give street and number): SUBURBAN HOSPITAL
4b. City, Town, or Location of Death: BETHESDA
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 159-34-2567
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 55 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 06/05/1941
9. Birthplace (State or Foreign Country): PENNSYLVANIA

Usual Residence of Decedent

10e. State: MARYLAND
10b. County: MONTGOMERY
10c. City, Town or Location: ROCKVILLE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 10500 ROCKVILLE PIKE #1011
10f. Zip Code: 20852
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): COMPUTER PROGRAMMER
16b. Kind of Business/Industry: STATISTICAL RESEARCH

17. Father's Name (First, Middle, Last): PAUL GOLDSTEIN
18. Mother's Name (First, Middle, Maiden Surname): DOROTHY SELTZER

19a. Informant's Name/Relationship (Type, Print): ROLLAND ROWEN/HUSBAND
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10500 ROCKVILLE PIKE #1011, ROCKVILLE, MD 20852

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): JUDEAN MEMORIAL GARDENS
Date: 5/22/97
20c. Location - City or Town, State: OLNEY, MARYLAND

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE - ROCKVILLE, MARYLAND 20852

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. METASTATIC BREAST CANCER — YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D15046
29d. Date signed (Month, Day, Year): MAY 19, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): STEPHEN J. NEWMAN, MD, PA, 19261 MONTGOERY VILLAGE AVE, GAITHERSBURG, MD 20879

State Registrar

31. Date filed (Month, Day, Year): MAY 22 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17462

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BOBBY JOE RASNAKE SR.

2. Date of Death: Month MAY Day 21 Year 1997

3. Time of Death: 1445

4a. Facility Name (If not institution, give street and number): ATLANTIC GENERAL HOSPITAL

4b. City, Town, or Location of Death: BERLIN

4c. County of Death: WORCESTER

Funeral Director

5. Social Security Number: 218-36-2894

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 58 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): APRIL 18, 1939

9. Birthplace (State or Foreign Country): VIRGINIA

Usual Residence of Decedent

10a. State: DELAWARE

10b. County: SUSSEX

10c. City, Town or Location: SELBYVILLE

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: RT. 1 BOX 81B

10f. Zip Code: 19975

10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MECHANIC

16b. Kind of Business/Industry: AUTO

17. Father's Name (First, Middle, Last): LEWIS RASNAKE

18. Mother's Name (First, Middle, Maiden Surname): LEONA RASNAKE

19a. Informant's Name/Relationship (Type, Print): ELIZABETH N. RASNAKE/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): RT. 1 BOX 81B, SELBYVILLE, DELAWARE 19975

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): SALISBURY CREMATORY

Date: 5/23/97

20c. Location - City or Town, State: SALISBURY, MARYLAND

21. Signature of Funeral Service Licensee: Charles W Hastings

22. Name and Address of Facility: HASTINGS FUNERAL HOME, SELBYVILLE, DELAWARE 19975

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. pneumonia — 4 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: 2/cirrhosis

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one): Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Robert Durkin Physician

29c. License number: H44283

29d. Date signed (Month, Day, Year): 5/21/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert Durkin 9733 Healthway Drive Berlin, MD

State Registrar

31. Date filed (Month, Day, Year): MAY 23 1997

32. Registrar's Signature: Judi Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17463

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ARTHUR M. REED

2. Date of Death: Month MAY Day 22, Year 1997

3. Time of Death: 2:00 AM

4a. Facility Name (If not institution, give street and number): McCREADY MEMORIAL HOSPITAL

4b. City, Town, or Location of Death: CRISFIELD

4c. County of Death: SOMERSET

Funeral Director

5. Social Security Number: 209-12-1027

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 93 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 21, 1904

9. Birthplace (State or Foreign Country): Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Somerset

10c. City, Town or Location: Crisfield

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 12 West Main St.

10f. Zip Code: 21817

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No. If Yes, Give Year or Dates: World War II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 5 | College (1-4or 5+): - - -

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Seaman

16b. Kind of Business/Industry: U.S. Corps of Engineers

17. Father's Name (First, Middle, Last): Morgan Reed

18. Mother's Name (First, Middle, Maiden Surname): Emma Birch

19a. Informant's Name/Relationship (Type, Print): Jean M. Vandiver (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3610 Terrace Drive - Annandale, VA 22003

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Crisfield Cemetery | Date: 5/25/97

20c. Location - City or Town, State: Crisfield, MD

21. Signature of Funeral Service Licensee: Robert H. Bradshaw

22. Name and Address of Facility: Bradshaw & Sons Funeral Home, 306 W. Main St. - Crisfield, MD 21817

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ENTEROCOCCUS FECIUM URINARY TRACT INFECTION — DAYS

Due to (or as a consequence of):
b. SUPRAPUBIC CYSTOSTOMY — MONTHS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DYSMYELOPOIESIS, THROMBOCYTOPENIA

PARKINSON'S DISEASE, ALZHEIMER'S

DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D48002

29d. Date signed (Month, Day, Year): 5/22/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): OLUSEGUN OGUNFOWORA, McCREDY MEMORIAL HOSPITAL, 201 HALL HIGHWAY CRISFIELD MD 21817

State Registrar

31. Date filed (Month, Day, Year): MAY 28 1997

32. Registrar's Signature: Julia Stevenson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17464

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Charles E. Robertson Jr

2. Date of Death Month: MAY Day: 24 Year: 1997

3. Time of Death: 2042

4a. Facility Name *(If not institution, give street and number)*: Sacred Heart Hospital

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 217-18-4856

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 72 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 9 1925

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Md

10b. County: Allegany

10c. City, Town or Location: Westernport

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 328 Front Steet

10f. Zip Code: 21562

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? [X] Yes 2 [ ] No If Yes, Give Year or Dates: US Navy

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): Unknown; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Electrician

16b. Kind of Business/Industry: Economy Electric Co.

17. Father's Name *(First, Middle, Last)*: Charles E. Robertson Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Rhoda Donald

19a. Informant's Name/Relationship *(Type, Print)*: Anna Robertson

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 328 Front St. Westernport, Md. 21562

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Cumberland Crematory Date: 5/25/97

20c. Location - City or Town, State: Cumberland Md.

21. Signature of Funeral Service Licensee: Wayne Boal

22. Name and Address of Facility: Boal Funeral Home 111 Church St, Westernport, Md. 21562

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the *mode* of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. METASTATIC LUNG CARCINOMA — 6 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

AORTIC VALVE PROSTHESIS

HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Sidhu

29c. License number: D 26907

29d. Date signed *(Month, Day, Year)*: MAY 25, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sidhu, Harjit, M.D. 925 Bishop Walsh Rd, Cumberland, MD 21502

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

4 VA

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 27 1997

32. Registrar's Signature: Jodi Bruchon-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17465

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Jimmie G. Roberts , Sr.

2. Date of Death Month Day Year: May 18, 1997

3. Time of Death: 6:00 P.M.

4a. Facility Name *(If not institution, give street and number)*: Holy Cross Hospital

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-38-4681

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 66 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov. 11, 1930

9. Birthplace *(State or Foreign Country)*: North Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Edgewater

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 4086 Cadle Creek Rd.

10f. Zip Code: 21037

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1946-49

13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Owner

16b. Kind of Business/Industry: United Sheet Metal, Inc.

17. Father's Name *(First, Middle, Last)*: Terrell N. Roberts, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Juanita Elizabeth Ramsey

19a. Informant's Name/Relationship *(Type, Print)*: Jimmie G. Roberts, Jr./Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9220 Edgeworth Dr. Capitol Hgts., Maryland 20743

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Roberts Family Cemetery

Date: 5-22-97

20c. Location - City or Town, State: Romney, West Virginia

21. Signature of Funeral Service Licensee: Matt Kalas

22. Name and Address of Facility: GEORGE P. KALAS FUNERAL HOME 2973 Solomons Island Rd. Edgewater, Md. 21037

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. malignant mesothelioma — 6 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Acute renal failure

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Bruce A. Silver, MD

29c. License number: D21463

29d. Date signed *(Month, Day, Year)*: 5-19-97

30. Name and address of person who completed cause of death (Item 23e) (Type/Print): BRUCE A. SILVER, MD 2101 Medical Park Dr., Silver Spring, MD 20902

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 21 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 17466

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Katherine Elizabeth Rinehart
2. Date of Death (Month, Day, Year): May 14, 1997
3. Time of Death: 11:20 PM
4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 214-10-2309
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 13, 1910
9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1035 North Market Street
10f. Zip Code: 21701
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Meat Wrapper
16b. Kind of Business/Industry: Supermarket

17. Father's Name (First, Middle, Last): Charles BURKHOLDER
18. Mother's Name (First, Middle, Maiden Surname): Dona COOK

19a. Informant's Name/Relationship (Type, Print): Mr. Richard W. Rinehart, Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1035 North Market St., Frederick, Maryland 21701

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mount Olivet Cemetery, May 17, 1997
20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: ▶ Richard E. Graf M00255
22. Name and Address of Facility: Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. gastrointestinal bleed	2 hrs
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Cirrhosis of the liver	10 yrs
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Carmen A Hernandez MD
29c. License number: D35248
29d. Date signed (Month, Day, Year): 5/15/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 310 W 9th ST, Frederick Md 21701

State Registrar

31. Date filed (Month, Day, Year): MAY 16 1997
32. Registrar's Signature: Julia Thurlow-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEM#27,28aTHRU28f PER M.E. FLM#G751 9-2-97J.A. **Certificate of Death** Reg. No. 97 17467

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner — **To Be Completed by Funeral Director**

1. Decedent's Name (First, Middle, Last): BERNARD EMERSON REYNOLDS
2. Date of Death: Month MAY Day 12, Year 1997
3. Time of Death: 2:40 AM
4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 220-09-8182
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthday): 79 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb 7 1918
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Frederick
10c. City, Town or Location: Brunswick
10d. Inside City Limits: 1 X Yes 2 ☐ No
10e. Street and Number: 21 West "H" Street
10f. Zip Code: 21716
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 X Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 5 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Exterminator
16b. Kind of Business/Industry: Montgomery County Public Schools

17. Father's Name (First, Middle, Last): William F. Reynolds
18. Mother's Name (First, Middle, Maiden Surname): Dasie S. Morrison

19a. Informant's Name/Relationship (Type, Print): Melinda Duncan
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 21 West "H" St. Brunswick MD 21716

20a. Method of Disposition: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Samples Manor Cemetery
Date:
20c. Location - City or Town, State: Samples Manor, MD

21. Signature of Funeral Service Licensee: Barbara A. Williams
Barbara A. Williams, Owner
22. Name and Address of Facility: John T. Williams Funeral Home 100 Petersville Rd Brunswick MD 21716

Physician /Medical Examiner — **Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Pulmonary embolism — Minutes
Due to (or as a consequence of): Fracture of hip
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of): Fall
c. Due to (or as a consequence of):
d.

Donald Gwirtz MD
CERTIFICATION APPROVED BY MEDICAL EXAMINER

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 X Yes 2 ☐ No
26. Place of Death (Check only one): Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Natural 2 X Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year): MAY 9-10-1997
28b. Time of Injury: unknown M
28c. Injury at Work? 1 ☐ Yes 2 X No
28d. Describe how injury occurred: FELL OUT OF BED
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): FREDERICK MEMORIAL HOSPITAL
28f. Location (Street and Number or Rural Route Number, City or Town, State): FREDERICK MEMORIAL HOSP. FREDERICK MD.

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D25-91
29d. Date signed (Month, Day, Year): 5/12/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 201 Thomas Johnson Dr. FREDERICK MD 21702

State Registrar

31. Date filed (Month, Day, Year): MAY 14 1997
32. Registrar's Signature: Patricia Davidson-Randall

DHMH 16 Rev 6/95

97-2591-021
CIP
JAMES REESE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17468

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: James Edgar REESE, Jr
2. Date of Death Month / Day / Year: MAY 11, 1997
3. Time of Death: 6:20PM
4a. Facility Name *(If not institution, give street and number)*: 11320 ALTON ROAD
4b. City, Town, or Location of Death: FREDERICK
4c. County of Death: FREDERICK

Funeral Director

5. Social Security Number: 425-44-0124
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 67 Yrs. (If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.)
8. Date of Birth *(Month, Day, Year)*: Aug 22,1929
9. Birthplace *(State or Foreign Country)*: Mississippi

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 11320 Alton Road
10f. Zip Code: 21701
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1947-1968
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Lab Administrator
16b. Kind of Business/Industry: Health Care

17. Father's Name *(First, Middle, Last)*: James Edgar REESE, Sr
18. Mother's Name *(First, Middle, Maiden Surname)*: Maebelle NICHOLS

19a. Informant's Name/Relationship *(Type, Print)*: Betty Jane Reese/Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 11320 Alton Road, Frederick, Maryland 21701

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Smithsburg Crematory
Date: May 16,1997
20c. Location - City or Town, State: Smithsburg,Maryland

21. Signature of Funeral Service Licensee: Kathryn Robens M00706
22. Name and Address of Facility: Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, MD 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. INTRA-ORAL GUNSHOT WOUND
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: DIABETES MELLITUS; HYPERTENSION, MANIC DEPRESSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? PARTIAL 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☐ Natural 2☐ Accident 3☒ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*: 5/11/1997
28b. Time of Injury: 5:46P M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: SELF-INFLICTED GUNSHOT WOUND
28e. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*: RESIDENCE
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: 11320 ALTON ROAD FREDERICK, MARYLAND

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Dennis J. Chute M.D.
29c. License number: O.C.M.E.
29d. Date signed *(Month, Day, Year)*: MAY 12, 1997
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DENNIS J. CHUTE M.D., 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 13 1997
32. Registrar's Signature: Theodore Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17469

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Olive Barbara REYNOLDS
2. Date of Death Month, Day, Year: May 10, 1997
3. Time of Death: 1:00 AM
4a. Facility Name (If not institution, give street and number): Citizens Nursing Home
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 038-14-3388
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 2, 1920
9. Birthplace (State or Foreign Country): Rhode Island

Usual Residance of Decadant

10e. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 8608 Pine Cliff Drive
10f. Zip Coda: 21701
10g. Citizen of What Country?: U.S.A.
11. Maritel Status: 1☐ Navar Marriad 2☒ Married 3☐ Widowed 4☐ Divorcad
12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Giva Yeer or Datas:
13. Was Dacedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puerto Rican, atc.): 1☐ Yas 2☒ No Specify:
14. Race - Amarican Indien, Black, White, atc. Specify: White
15. Decedent's Education (Specify only highast grada completed): Elamentery/Secondary (0-12): — College (1-4or 5+): 5+
16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired): Homemaker
16b. Kind of Businass/Industry: Own Home
17. Fathar's Nama (First, Middle, Last): William STRICKLAND
18. Mother's Nama (First, Middle, Maidan Surnama): Florence SANDERSON
19a. Informant's Name/Relationship (Typa, Print): Mr. Victor T. Reynolds, Husband
19b. Mailing Addrass (Street and Numbar or Rural Routa Number, City or Town, State, Zip Coda): 8608 Pine Cliff Drive, Frederick, Md. 21701
20a. Mathod of Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)
20b. Place of Disposition (Nama of cemetary, crematory or other placa): Smithsburg Crematory, May 12, 1997
20c. Location - City or Town, Stata: Smithsburg, Md.
21. Signatura of Funaral Sarvice Licansae: Richard E. Graf MO0255
22. Nama and Addrass of Facility: Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Maryland 21701

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such es cardiac or raspiratory arrast, shock, or haart failure. List only ona causa on aach lina.

Approximata Interval Between Onset end Death

Immediata Causa (Final disaase or condition rasulting in daath)
a. Pneumonia — 3 days
Dua to (or as a consequence of):
b. Alzheimers — years
Sequentially list conditions, if any, leading to immadiata causa. Enter Undarlying Causa (Disaasa or injury that initiated events rasulting in daath) Last
Due to (or as a consaquance of):
c. —
Due to (or es e consequance of):
d. —

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying cause givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performad? 1☐ Yas 2☒ No

24b. Were autopsy findings available prior to completion of causa of death? 1☐ Yas 2☐ No

25. Wes casa rafarrad to medical examinar? 1☐ Yas 2☒ No

26. Place of Death (Check only ona): Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA Othar: 4☒ Nursing Homa 5☐ Rasidence 8☐ Othar (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding Investigation 6☐ Could not be determined

28a. Data of Injury (Month, Day Yaar)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Placa of Injury - At homa, farm, straat, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one): 1☒ Certifying Phyaician: To the best of my knowladga, death occurred at the tima, date and placa, and due to the causa(s) and mannar as stated. 2☐ Medical Examiner: On tha basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) and mannar stated.

29b. Signature and title of certifier: Dr. Halvorson
29c. Licansa number: D 22019
29d. Data signed (Month, Day, Yaar): May 12, 1997

30. Nama and addrass of parson who completed causa of daath (Item 23e) (Type, Print): Dr. Lloyd E. Halvorson MD 1475 Taney Avenue, Frederick, Maryland 21702

State Registrar

31. Date filed (Month, Day, Yaar): MAY 12 1997
32. Registrar's Signatura: Gretchen Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

97 17470

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ALLAN LEE ROBERTSON			2. DATE OF DEATH (Month, Day, Year): MAY 16 97	3. TIME OF DEATH: 6:18 P M
4. SOCIAL SECURITY NUMBER: 213-05-1515	5. SEX: 1 XX M 2 ☐ F	6. AGE (In yrs. last birthday): 84 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): May 30, 1912	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 405 East Main Street		9b. CITY, TOWN OR LOCATION OF DEATH: Westminster		9c. COUNTY OF DEATH: Carroll
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Carroll	10c. CITY, TOWN OR LOCATION: Westminster		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 405 East Main Street		10f. ZIP CODE: 21157		10g. CITIZEN OF WHAT COUNTRY?: United States
11. MARITAL STATUS: 1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 XX NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 XX NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10 / College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Self-employed		16b. KIND OF BUSINESS/INDUSTRY: Printing
17. FATHER'S NAME (First, Middle, Last): Leslie Clinton Robertson		18. MOTHER'S NAME (First, Middle, Maiden Surname): Pansy Laura McGee		
19a. INFORMANT'S NAME (Type/Print): Margaret Robertson		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 405 E. Main Street, Westminster, MD 21157		
20a. METHOD OF DISPOSITION: 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Westminster Cemetery	DATE: 5/19	20c. LOCATION — City or Town, State: Westminster, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Suzanne Doherty Myers		22. NAME AND ADDRESS OF FACILITY: Myers Funeral Home 91 Willis Street, Westminster, MD 21157		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. LUNG CANCER — 1 month

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Vernon Eldora, MD	29c. LICENSE NUMBER: D26385	29d. DATE SIGNED (Month, Day, Year): ▶ 5-19-97
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print): Vernon Eldora 218 Washington [illegible]		
31. DATE FILED (Month, Day, Year): MAY 19 1997	32. REGISTRAR'S SIGNATURE: Julia Davidson Randall	

DNMN-18 Rev 1/89

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17471

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last)	2. Dete of Deeth Month Dey Yeer	3. Time of Deeth
Sylvia Jane Robinson	May 14,1997	18:50Hrs

4e. Feclility Neme (If not institution, give street end number)	4b. City, Town, or Location of Deeth	4c. County of Deeth
3825 Conowingo Road	Darlington	Harford

Funeral Director

5. Sociel Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Yeer: Months / Deys	If Under 24 Hrs.: Hours / Min.	8. Dete of Birth (Month, Dey, Yeer)	9. Birthplece (State or Foreign Country)
197-01-2543	1☐ M 2☒ F	80 Yrs.			8/16/1916	West Virginia

Usuel Residence of Decedent

10e. Stete	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Harford	Darlington	1☐ Yes 2☒ No

10e. Street end Number	10f. Zip Code	10g. Citizen of What Country?
3825 Conowingo Road	21034	United States

11. Meritel Stetus	12. Wes Decedent Ever in U.S. Armed Forces?	13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indien, Bleck, White, etc.
1☐ Never Married 2☐ Merried 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Yeer or Detes:	1☐ Yes 2☒ No *Specify:*	*Specify:* White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondery (0-12)	College (1-4or 5+)		
Unknown		Homemaker	Own Home

17. Fether's Neme (First, Middle, Last)	16. Mother's Neme (First, Middle, Meiden Surneme)
Absolom Belcher	Amanda Green

19e. Informent's Neme/Reletionship (Type, Print)	19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)
Jean Ann Blackburn	Route 2 Box 1550 Troy, VA 22974

20e. Method of Disposition	20b. Piece of Disposition (Neme of cemetery, cremetory or other piece)	Dete	20c. Location - City or Town, Stete
1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)	Dublin Southern Cem.	5/19	Darlington, MD

21. Signeture of Funerel Service Licensee: Jeffrey P. Lovelace

22. Neme end Address of Feciility: Harkins Funeral Home, Inc., Delta, PA

Physician /Medical Examiner

23e. Pert I. Enter the diseese, or complicetions thet cesed the deeth. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heert failure. List only one ceuse on eech line.

		Approximate Interval Between Onset end Deeth
Immediete Ceuse (Finel diseese or condition resulting in deeth)	e. HASCVD	
	Due to (or es e consequence of):	
Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in deeth) Lest	b.	
	Due to (or es e consequence of):	
	c.	
	Due to (or es e consequence of):	
	d.	

Pert II. **Other significent conditions** contributing to deeth but not resulting in the underlying cause given in Pert I.

23b. **Did tobecco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Wes case referred to medical exeminer?	26. Place of Deeth (Check only one)	
1☒ Yes 2☐ No	Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Menner of Death	28e. Dete of Injury (Month, Dey Yeer)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined	NA	NA M	1☐ Yes 2☒ No	NA

28e. Piece of injury - At home, ferm, street, fectory, office building, etc. (Specify)	28f. Locetion (Street end Number or Rurel Route Number, City or Town, Stete)
NA	NA

29e. Certifier (Check only one) 1☐ **Certifying Physicien:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Exeminer:** On the basis of exemineticn and/or investigetion, in my opinion, deeth occurred et the time, dete end piece, and due to the cause(s) end menner steted.

29b. Signeture end title of certifier	29c. License number	29d. Dete signed (Month, Day, Year)
DME	OCME	May 15th 1997

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print)
G.S.Prabhu 1810 Belair Rd # 102 Fallston MD. 21047 410-879-6564.

State Registrar

31. Dete filed (Month, Dey, Yeer)	32. Registrar's Signeture
MAY 19 1997	

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

97 17472

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Sarah E. Russ						2. DATE OF DEATH (Month, Day, Year): April 13, 1997	3. TIME OF DEATH: 6:17 AM
4. SOCIAL SECURITY NUMBER: 219-58-1384	5. SEX: 1 ☐ M 2 ☒ F XX	6. AGE (In yrs. last birthday): 85 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.		7. DATE OF BIRTH (Month, Day, Year): JAN. 8, 1912	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): WESTMINSTER NURSING REHAB CENTER			9b. CITY, TOWN OR LOCATION OF DEATH: WESTMINSTER			9c. COUNTY OF DEATH: CARROLL	

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: CARROLL	10c. CITY, TOWN OR LOCATION: WESTMINSTER	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 358 FAIR AVENUE		10f. ZIP CODE: 21157	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 XX NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): -0-	College (1-4 or 5+): -0-	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): NEVER WORKED	16b. KIND OF BUSINESS/INDUSTRY: N/A

17. FATHER'S NAME (First, Middle, Last): JAMES H. RUSS	18. MOTHER'S NAME (First, Middle, Maiden Surname): HATTIE SATCHELL
19a. INFORMANT'S NAME (Type/Print): JOAN R. TAYLOR/ NIECE	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9551 QUAIL HOLLOW DR.#102, ST. MICHAELS, MD

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): SPRING HILL CEMETERY	DATE: 4-16	20c. LOCATION — City or Town, State: EASTON, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ JOHN R. MERCER CFSP	22. NAME AND ADDRESS OF FACILITY: FELLOWS, HELFENBEIN & NEWNAM FUNERAL H. 200 S. HARRISON ST., EASTON, MD		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Lymphoma	Thyears
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☑

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	26a. DATE OF INJURY (Month, Day, Year) / 26b. TIME OF INJURY M / 26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	26d. DESCRIBE HOW INJURY OCCURED
	26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD	29c. LICENSE NUMBER: D33184	29d. DATE SIGNED (Month, Day, Year): ▶ April 15, 1997

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Jonathan D. Kushner 114 Business Center Drive Reisterstown, MD

31. DATE FILED (Month, Day, Year): APR 18 1997	32. REGISTRAR'S SIGNATURE: Kathleen Tridson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 6876, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17473

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: LAWRENCE EUGENE RAINBOLT

2. Date of Death Month / Day / Year: May 27 1997

3. Time of Death: 4:20 AM

4a. Facility Name *(If not institution, give street and number)*: Charlotte Hall Veterans' Home

4b. City, Town, or Location of Death: Charlotte Hall

4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 343-18-7304

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 75 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 12, 1922

9. Birthplace *(State or Foreign Country)*: Illinois

Usual Residence of Decedent

10a. State: Maryland

10b. County: Calvert

10c. City, Town or Location: Huntingtown

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 3281 Juniper Lane

10f. Zip Code: 20639

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: 1943-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6 — College (1-4 or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Carpenter

16b. Kind of Business/Industry: Construction

17. Father's Name *(First, Middle, Last)*: James Rainbolt

18. Mother's Name *(First, Middle, Maiden Surname)*: Hailey Evans

19a. Informant's Name/Relationship *(Type, Print)*: David Rainbolt - Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2205 Neville Ct., Waldorf, MD 20601

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Huntt Crematory

Date: 5-29-97

20c. Location - City or Town, State: Waldorf, Maryland

21. Signature of Funeral Service Licensee: Shannon W. Ramirez

Shannon W. Ramirez MO0798

22. Name and Address of Facility: Huntt Funeral Home, Inc.
P. O. box 156, Waldorf, MD 20604-0156

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY failure — FEW minutes

Due to (or as a consequence of):

b. CARCINOMA OF LUNG — FEW MONTH

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

METASTATIC BONE disease

BENIGN Prostatic HYPERTROPHY

HYPERCALCEMIA OF MALIGNENCY

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [X] Nursing Home 5 [ ] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury: NA M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*: NA

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: NA

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ATENDING

29c. License number: D-44436

29d. Date signed *(Month, Day, Year)*: May 27 97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Ashvin J. Patel, 603 Post Office Road #207, Waldorf, MD 20602

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 2 8 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED # 8. P.G.C. 5-20-97 cr

Certificate of Death

Reg. No. 97 17474

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
DOROTHY E. ROLAND	MAY 12, 1997	2:05A.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
ST. CATHERINE'S NURSING CENTER	EMMITSBURG	FREDERICK

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
578-07-5007	1☐ M 2☒ F	82 Yrs.			~~May 12, 1997~~ JUNE 5, 1914	Washington D.C.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Frederick	Emmitsburg	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
331 S. Seton Avenue	21727	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Clerk	Government

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Thomas H. Green	Mary M. Carroll

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Virginia Hertel/neice	11139 Old Frederick Road Thurmont, MD 21788

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Cedar Hill Cemetery	5-15	Suitland, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Kimberly C Busch-Tonic	Marshall's Funeral Home 4308 SUITLAND ROAD SUITLAND, MD 20746

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): Ischemic cardiovascular disease — 6 mos.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Advanced Rheumatoid Arthritis

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Fibrotic Lung Disease

Osteoporosis

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Bonita J Krempel-Portier	H4403	MAY 12, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BONITA J. KREMPEL-PORTIER, D.O. 310 S. SETON AVE., EMMITSBURG, MD. 21727

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 20 1997	Judy Thurlow-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

CR

(2)

97-2585-033
CMK
DAVID EUGENE ROSS, JR.
Items:28e,f per MEO G-749 7/14/97 dh

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17475

Physician /Medical Examiner

1. Decedent's Nema *(First, Middle, Last)*: David Eugene Ross, Jr.
2. Deta of Deeth Month MAY Dey 11, Yeer 1997
3. Time of Death: 0415AM
4e. Feciility Name *(If not institution, give street and number)*: 5000 BLOCK SILVER HILL ROAD
4b. City, Town, or Location of Death: SUITLAND
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 212-11-4274
6. Sex: 1☒M 2☐F
7. Age *(In yrs. last birthdey)*: 17 Yrs.
If Under 1 Yaar: Months / Deys
If Under 24 Hrs.: Hours / Min.
6. Data of Birth *(Month, Dey, Yeer)*: March 20,1980
9. Birthpiace *(Stete or Foreign Country)*: Cheverly,Md.

Usuel Residence ot Decedent

10e. State: Maryland
10b. County: Prince Georges'
10c. City, Town or Location: Forestville
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street end Number: 2339 Seton Way
10f. Zip Code: 20747
10g. Citizen of Whet Country?: USA

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Yaar or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- It Yes, specify Cuben, Mexican, Puarto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Rece - Americen Indien, Bleck, White, etc. *Specify:* BLACK

15. Decedent's Educetion *(Specify only highest grade completed)*
Elementery/Secondery (0-12): 11th
College (1-4or 5+):
16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Student
16b. Kind of Business/Industry: P.G. County Public Sch

17. Fether's Nema *(First, Middle, Last)*: David eugene Ross, Sr.
18. Mother's Nama *(First, Middle, Meiden Surneme)*: Lynette Robinson

19e. Intorment's Name/Reletionship *(Type, Print)*: David E. Ross,Sr./father
19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 2339 Seton Way Forestville,Md. 20747

20e. Method of Disposition: 1☒Buriel 2☐Cremetion 3☐Removel trom Stete 4☐Donetion 5☐Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, crematory or other piece)*: Lincoln Memorial Cemetery
Date: 5/20/97
20c. Location - City or Town, Stete: Suitland,Md.

21. Signeture of Funerel Service Licensee: Shelly Bell
22. Neme end Addrass of Facility: Robert G. Mason Funeral Home, Inc. 1661 Good Hope Road, S.E. Wash.,DC 20020

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications thet ceused the deeth. Do not enter the mode of dying, such as cerdiac or raspiratory arrest, shock, or heert feilure. List only one ceuse on each line.

Approximete Interval Between Onset and Deeth

Immediete Ceuse (Finel diseesa or condition resulting in deeth): e. Multiple Injuries
Due to (or es e consequence ot):

Sequentielly list conditions, if eny, leeding to immediete causa. Entar Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest:
b.
Due to (or es e consequence ot):
c.
Due to (or es e consequence ot):
d.

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☑Yes 2☐No

24b. Were autopsy findings available prior to completion ot ceuse of deeth? 1☑Yes 2☐No

25. Wes cese referred to medical examiner? 1☒Yes 2☐No

26. Piece ot Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpetient 3☐DOA Other: 4☐Nursing Homa 5☐Residance 6☒Other *(Specify)* AT SCENE

27. Manner of Deeth: 1☐Neturel 2☑Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28e. Dete ot Injury *(Month, Dey Yeer)*: 5-11-97
28b. Time ot Injury: 0209 M
28c. Injury et Work? 1☐Yes 2☑No
28d. Describe how injury occurred: Driver - Auto, fixed collision object

28e. Piece of Injury - At home, term, street, factory, office building, etc. *(Specify)*: roadway
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*: Silver Hill Road & Plaza Drive Suitland, Maryland

29a. Certifier *(Check only one)*: 1☐**Certifying Physician:** To the best ot my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner as steted. 2☒**Medical Examiner:** On the besis of examination end/or Investigetion, in my opinion, deeth occurred at the time, dete end place, end due to the ceuse(s) end manner stated.

29b. Signeture end title ~~of certifier~~: [signature]
29c. License number: O.C.M.E.
29d. Dete signed *(Month, Dey, Yeer)*: MAY 11, 1997

30. Neme end eddress ot person who completed cause ot deeth (Item 23e) (Type, Print): David R Fowler 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed *(Month, Day, Yeer)*: MAY 20 1997
32. Registrer's Signetura: [signature]

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 17476

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Hattie B. Routh

2. Date of Death: Month May Day 17 Year 1997

3. Time of Death: 6:05a.m.

4a. Facility Name (If not institution, give street and number): Manor Care Nursing Home

4b. City, Town, or Location of Death: Chevy Chase

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 577-20-0080

6. Sex: 1☐ M 2☒ F XX

7. Age (In yrs. last birthday): 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 11/23/15

9. Birthplace (State or Foreign Country): TENN

Usual Residence of Decedent

10a. State: DC

10b. County: N/A

10c. City, Town or Location: WASHINGTON

10d. Inside City Limits: XX☑ Yes 2☐ No

10e. Street and Number: 2209EVARTS STREET NE

10f. Zip Code: 20018

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ XWidowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, atc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 10TH GRADE

College (1-4or 5+): NONE

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired): CHILD CARE

16b. Kind of Business/Industry: SELf Emp.

17. Father's Neme (First, Middle, Last): HENRY MIMS

18. Mother's Name (First, Middle, Meiden Surnema): LILLIE EDGE

19a. Informant's Name/Relationship (Type, Print): PATRICIA A. WHITEMAN

19b. Mailing Address (Straet and Number or Rural Route Number, City or Town, Stete, Zip Code): SAME AS 10A,B,C,D,E&F

20a. Method of Disposition: XX☑ 1 Burial 2☐ Cramation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cramatory or other place): HARMONY MEMORIAL PARK CEMETERY 5/24/97

20c. Location - City or Town, Stata: LANDOVER, MD

21. Signature of Funeral Service Licensee: Juan D. Smith

22. Name and Address of Facility: John T. Rhines & Co. 3030 12th. St.,N.E. Wash.,D.C. 20017

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

7

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failura. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Colon Cancer — weaks

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Causa (Disaase or Injury that initiated events resulting in death) Last:

b. Anemia — days

Dua to (or as a consequence of):

c.

Due to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to daath but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☑ No

24b. Wara autopsy findings available prior to completion of causa of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, straet, factory, office bulding, etc. (Spacify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowladga, daath occurrad at tha time, date and place, and dua to tha cause(s) and mannar as statad. 2☐ **Medical Examiner**: On the basis of axamination and/or investigation, in my opinion, daath occurrad at tha tima, data and place, and dua to tha causa(s) and mannar stated.

29b. Signature and title of certifier: ▶ [signature] MD

29c. License number: D33357

29d. Date signed (Month, Day, Year): 5/19/97

30. Name and address of person who complatad causa of daath (Item 23a) (Type, Print): Lee Jonathan Musher MD 5530 Wisconsin Ave Suite 1045 Chevy Chase MD

To the Hospital or Attending Physician: Tha law requires that tha death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, paga 2 should be detached for usa as the burial-transit

Division of Vital Records, P.O. Box 68760,

(8)

State Registrar

31. Date filed (Month, Day, Year): MAY 21 1997

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended 5/23/97 #26 P.G.C. L.S.M.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 17477
Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
LILLIE RODGERS	MAY 19, 1997	1:22 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
FORT WASHINGTON HOSPITAL	FORT WASHINGTON	PRINCE GEORGES

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
069-14-7543	1☐M 2☒F	83 Yrs.			3/17/14	Union, S.C.

Usual Residence of Decedent

10e. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Prince George	Ft. Washington	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1101 Montezuma Drive	20744	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th		Licensed Practical Nurse	Health Care

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Ernest Gist	Cozy Hughes

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Edward Rodgers/Husband	Same as # 10 above

20a. Method of Disposition	20b. Place of Disposition (Name of cemetary, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Ft. Lincoln Cem.	5/23/97	Brentwood, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Gary W. Craft	H.S. Washington & Sons, inc. 4925 Burroughs Ave., N.E.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ASCVD - MULTIPLE CVA.	1YR
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ASHD - CARDIOMYOPATHY
HTN - Multiple

23b. **Did tobacco use contribute to the cause of death?** 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in *my* opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Michael D. Levine M.D.	D24945	MAY 20, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Michael D. Levine, M.D. 7801 Old Branch Ave. # 409, Clinton, Md. 20735

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 23 1997	Gilbert Hudson Rudolph

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(6)

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17478

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Lloyd Lee Rector
2. Date of Death Month: May Day: 1 Year: 1997
3. Time of Death: 2:20pm
4a. Facility Name *(If not institution, give street and number)*: Physicians Memorial Hospital
4b. City, Town, or Location of Death: La Plata
4c. County of Death: Charles

Funeral Director

5. Social Security Number: 579-26-2942
8. Sex: 1☒M 2☐F
7. Age *(In yrs. last birthday)*: 70 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 1, 1926
9. Birthplace *(State or Foreign Country)*: Washington DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: St.Mary's
10c. City, Town or Location: Mechanicsville
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 39014 Jacqueline St.
10f. Zip Code: 20659
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):
18e. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Mechanic
16b. Kind of Business/Industry: Refrigeration

17. Father's Name *(First, Middle, Last)*: William James Rector
18. Mother's Name *(First, Middle, Maiden Surname)*: Sara Jeanette Whitlock Rector

19e. Informant's Name/Relationship *(Type, Print)*: Jessie Marie Rector
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 39014 Jacqueline St., Mechanicsville, MD 20659

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Charles Memorial Gardens
Date: 5/5/97
20c. Location - City or Town, State: Leonardtown, MD

21. Signature of Funeral Service Licensee: Michael L. Gardiner
22. Name and Address of Facility: Mattingley-Gardiner Funeral Home, P.A. Leonardtown, MD 20650

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Encephalopathy
Due to (or as a consequence of):
b. atherosclerotic cardiovascular disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
Due to (or as a consequence of):
c. diabetes Mellitus
Due to (or as a consequence of):
d. renal failure

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☐No

28. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 8☐Other *(Specify)*

27. Manner of Death: 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28a. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Robert Pace
29c. License number: D-22574
29d. Date signed *(Month, Day, Year)*: 5/2/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROBERT PACE, MD 700 OLD LINE CENTER SUITE 202 WALDORF, MD 20601

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 06 1997
32. Registrar's Signature: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17479

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Charles Russell Robinson
2. Date of Death Month Day Year: May 10, 1997
3. Time of Death: 7:45 a.m.
4a. Facility Name (If not institution, give street and number): 35941 Washington Avenue
4b. City, Town, or Location of Death: Chaptico
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 217-42-0999
6. Sex: 1 ■ M 2 ☐ F
7. Age (In yrs. last birthday): 53 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): December 26, 1943
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Chaptico
10d. Inside City Limits: 1 ☐ Yes 2 ■ No
10e. Street and Number: 35941 Washington Avenue
10f. Zip Code: 20621
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ■ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 2 ■ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ■ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Heavy Equiptment Operator
16b. Kind of Business/Industry: Washington Sanitary Commission

17. Father's Name (First, Middle, Last): Louis Wellington Robinson
18. Mother's Name (First, Middle, Maiden Surname): Cecelia Ann Proctor

19a. Informant's Name/Relationship (Type, Print): Angela Crystal Robinson, Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 35941 Washington Avenue, Chaptico, Maryland 20621-0593

20a. Method of Disposition: 1 ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): Resurrection Cemetery
Date: 5-15-97
20c. Location - City or Town, State: Clinton, Maryland

21. Signature of Funeral Service Licensee: Edward N. Brinsfield, Jr., MD0052
22. Name and Address of Facility: Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, Maryland 20650-0279

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Carcinoma of The Spine — Month.
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Emphysema

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ■ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ■ Yes 2 ☐ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ■ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year):
28b. Time of Injury: M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred:
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify):
28f. Location (Street and Number or Rural Route Number, City or Town, State):

29a. Certifier (Check only one): 1 ☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ■ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D14285
29d. Date signed (Month, Day, Year): 12 May 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William D. Boyd II, M.D., 25365 Point Lookout Road, Leonardtown, Maryland 20650-1753

State Registrar

31. Date filed (Month, Day, Year): MAY 13 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

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Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17480

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Melvin Grimes Reed
2. Date of Death Month / Day / Year: May 16 1997
3. Time of Death: 1.21 P.M.
4a. Facility Name *(If not institution, give street end number)*: St. Mary's Hospital
4b. City, Town, or Location of Death: Leonardtown
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 577-28-1501
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 73 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June 25, 1923
9. Birthplace *(State or Foreign Country)*: Washington, D.C.

Usual Residence of Decedent

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Mechanicsville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 25955 Hills Drive
10f. Zip Code: 20659
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1943-1945
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*
Elementary/Secondary (0-12): 12
College (1-4or 5+):
18a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Civil Servant
16b. Kind of Business/Industry: Department of Agriculture

17. Father's Name *(First, Middle, Last)*: Melvin Grimes Reed
18. Mother's Name *(First, Middle, Maiden Surname)*: Estelle Allen

19a. Informant's Name/Relationship *(Type, Print)*: Katharine L. Reed Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 25955 Hills Drive, Mechanicsville, Maryland 20659

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: MD Veterans' Cemetery
Date: 5/20/97
20c. Location - City or Town, State: Cheltenham, Maryland

21. Signature of Funeral Service Licensee: Michael K. Blankenship
22. Name and Address of Facility: Brinsfield Funeral Home, P.A. P.O. Box 279, Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death) a.	SEPSIS	3 DAYS
Due to (or as e consequence of): b.	LEUKOCYTOPENIA	2 1/2 WEEKS
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in death) Lest — Due to (or es a consequence of): c.	PHARYNGEAL CARCINOMA	4 MONTHS
Due to (or es a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.: ACUTE RENAL FAILURE

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was en eutopsy performed? 1☐ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was cese referred to medicel examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpetient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es ateted. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Frank K — MD
29c. License number: D50350
29d. Date signed *(Month, Day, Year)*: MAY 19, 1997

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print): FRANK L. KRIGER M.D. 7c WALDORF, MD. 20602

State Registrar

31. Date filed *(Month, Dey, Year)*: MAY 19 1997
32. Registrar's Signeture: Julia Dawson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

MELVIN GRIMES REED
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17481

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Eleanor Jean Root
2. Dete of Deeth — Month: May Day: 17, Yeer: 1997
3. Time of Death: 6:25a.m.
4e. Fecility Nema (If not institution, give street end number): St. Mary's Hospital
4b. City, Town, or Location of Deeth: Leonardtown
4c. County of Deeth: St. Mary's

Funeral Director

5. Social Security Number: 349-12-1478
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthdey): 73 Yrs. — If Under 1 Yeer: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Yeer): September 19, 1923
9. Birthplece (Stete or Foreign Country): Illinois

Usuel Residance of Decedent

10e. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Park Hall
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 20310 Gilliam Drive
10f. Zip Code: 20667
10g. Citizen of Whet Country?: United States

11. Maritel Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispenic Orlgin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elemantary/Secondery (0-12); Collaga (1-4or 5+): 2
16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT usa ratired): Bookkeeper
16b. Kind of Business/Industry: Banking

17. Fether's Neme (First, Middle, Last): Forrest Robert Schaefer
18. Mother's Neme (First, Middle, Maiden Sumeme): Josephine Rotroff

19e. Informent's Neme/Reletionship (Type, Print): LeRoy J. Root Husband
19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 20310 Gilliam Drive, Park Hall, Maryland 20667

20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Charles Memorial Gardens
Dete: 5/21/97
20c. Locetion - City or Town, Stete: Leonardtown, MD

21. Signeture of Funeral Service Licensee: Edward N. Brinsfield, JR. MD0052
22. Neme end Address of Fecility: Brinsfield Funeral Home, P.A. P.O. Box 279, Leonardtown, Maryland 20650

Physician /Medical Examiner

23e. Pert I. Enter the diseese, or complicetions thet caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert failure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immedieta Ceuse (Finel diseese or condition resulting in deeth)
e. Acute respiratory Failure — 24 hrs.
Due to (or es a consequence of):
Sequantially list conditions, if eny, leading to immediete cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest
b. 2° to Acute exacerbation
Due to (or as e consequence of):
c. of COPD and pneumonia — 4 hrs
Due to (or es e consequenca of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.: severe COPD. CORONARY ARTERY DISEASE

23b. Did tobacco use contribute to the cauee of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24e. Was en eutopsy performed? 1☐ Yes 2☐ No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No

26. Plece of Deeth (Check only one): Hospital: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Locetion (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end mennar as stated. 2☐ **Medical Examiner:** On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, deta end plece, end due to the cause(s) end menner steted.

29b. Signeture and title of certifier: MD
29c. License number: D36206
29d. Dete signed (Month, Day, Yeer): 05/20/97

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): Kiran D. Mehta Leonardtown MD 20650.

State Registrar

31. Dete filed (Month, Day, Yeer): MAY 21 1997
32. Registrar's Signeture: Lisa Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME: ELEANOR JEAN ROOT
Division of Vital Records, P.O. Box 68760,

(3)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17482

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month / Day / Year)	3. Time of Death
Melanie Heather Raley	MAY 17 1997	11;45 P.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
St. Mary's Hospital	Leonardtown	St. Mary's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	If Under 1 Year: Days	If Under 24 Hrs.: Hours	If Under 24 Hrs.: Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
n/a	1☐ M 2■ F	Yrs.			12		May 17, 1997	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	St. Mary's	Park Hall	1☐ Yes 2■ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
P.O. Box 323	20670	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1■ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2■ No If Yes, Give Year or Dates:	1☐ Yes 2■ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
n/a		N/A	N/A

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Thomas Raley	Deanna Marie Stevens

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Deanna Marie Raley Mother	P.O. Box 323, Park Hall, Maryland 20670

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5■ Other (Specify) Donation	St. Mary's Hospital	5-17-97	Leonardtown, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Michael K. Blankenship	Brinsfield Funeral Home, P.A. P.O. Box 279, Leonardtown, Maryland 20650

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. prematurity	12 hours
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Premature labor	
	Due to (or as a consequence of):	
	c. Chorioamnionitis	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4■ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2■ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2■ No	Hospital: 1■ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1■ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1■ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ DR. ALAN ROTHBERG	D41434	May 17, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Alan E. Rothberg, M.D., 600 Moakley Street, Leonardtown, Maryland 20650

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 27 1997	Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

MELANIE HEATHER RALEY
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17483

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joyce Rae Rolle

2. Date of Death Month Day Year: May 18, 1997

3. Time of Death: 1:15 PM

4a. Facility Name (If not institution, give street and number): 1325 Laurel Lane

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 219-46-2339

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 49 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 21, 1947

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Carroll

10c. City, Town or Location: Westminster

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1325 Laurel Lane

10f. Zip Code: 21158

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondery (0-12):

College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nurse

16b. Kind of Business/Industry: Springfield Hospital

17. Father's Name (First, Middle, Last): William Durbin

18. Mother's Name (First, Middle, Maiden Surname): Hilda M. Smith

19a. Informant's Name/Relationship (Type, Print): Dr. Todd Winebrenner, son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1325 Laurel Lane, Westminster, MD 21158

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Carroll Cremations Inc. Date: 05/22/97

20c. Location - City or Town, State: Hampstead, MD

21. Signature of Funeral Service Licensee: ▶ Katherine Pritts-Switzer

22. Name and Address of Facility: Pritts Funeral Home & Chapel, 412 Washington Rd., Westminster, MD 21157

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. NON SMALL CELL LUNG CA — 3 mos

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Flavio Kruter

29c. License number: D35398

29d. Date signed (Month, Day, Year): 5/20/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Flavio Kruter, M.D., 684A Poole Rd. Westminster, MD 21157

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): MAY 2 1 1997

32. Registrar's Signature: ▶ Julia Anderson Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Items:8,17 per Infor.G-749 7/7/97 dh
Items:19a and b per infor. G-748 6/26/97 dh

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 97 17484

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Marie Norton Robertson
2. Date of Death: Month May Day 13, Yaer 1997
3. Time of Death: 11:10 a.m.
4a. Facility Name (If not institution, give street and number): 105 S. Queen Street (At Home)
4b. City, Town, or Location of Death: Chestertown
4c. County of Death: Kent

Funeral Director

5. Social Security Number: 146-24-4446
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug.25, ~~August 7~~, 1911
9. Birthplace (State or Foraign Country): New Jersey

Usual Residence of Decedent

10a. State: Maryland
10b. County: Kent
10c. City, Town or Location: Chestertown
10d. Insida City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 105A S. Queen Street
10f. Zip Code: 21620
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Give Year or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yas 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Educetion (Specify only highest grade completed): Elementery/Secondery (0-12): 11 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retirad): Homemaker
16b. Kind of Business/Industry: Domestic/Own Home

17. Father's Name (First, Middle, Last): Otto ~~Mieneke~~ Meincke
18. Mother's Name (First, Middle, Maiden Surneme): Catherine Grantz

19a. Informant's Name/Relationship (Type, Print): Minta N. Holmes/daughter; Richard Norton/Son
19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 1037 Gallery Road, Wilmington, DE 19805; 119 High Street, Chestertown, Maryland 21620

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Ramoval from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or othar place): Greenfield Cemetery/May 16, 1997 | Data
20c. Location - City or Town, State: Pennsylvania Lancaster County,

21. Signature of Funeral Service Licensee: Kirk D. Fellows
22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. RUPTURED BRONCHIAL AORTIC ANEURYSM
Due to (or as a consequence of):
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last: b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Othar signiflcant conditions** contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to tha cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of causa of death? 1☐ Yes 2☐ No

25. Wes cese referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)
27. Manner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Streat and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. 2☐ **Medical Examiner:** On the besis of axamination and/or investigation, in my opinion, death occurred at the tima, date and place, and due to the cause(s) and manner steted.
29b. Signature and title of certifier: John Seymour MD
29c. License number: D-13024
29d. Date signed (Month, Day, Year): 5-13-97

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): John Seymour, MD, 122 Speer Road, Chestertown, Maryland 21620

State Registrar

31. Date filed (Month, Day, Year): MAY 16 '97
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10
1

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17485

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ronald Wade Robinson, Sr.

2. Date of Death Month Day Year: May 25 1997

3. Time of Death: 4 45 AM

4a. Facility Name *(If not institution, give street and number)*: 527 Dillon Drive

4b. City, Town, or Location of Death: Lusby

4c. County of Death: Calvert

Funeral Director

5. Social Security Number: 225 50 8118

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 57 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 13 1940

9. Birthplace *(State or Foreign Country)*: Washington DC

Usual Residence of Decedent

10a. State: Maryland

10b. County: Calvert

10c. City, Town or Location: Lusby

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 527 Dillon Drive

10f. Zip Code: 20657

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1956-1958

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Truck Driver

16b. Kind of Business/Industry: Trucking

17. Father's Name *(First, Middle, Last)*: Wade Hampton Robinson

18. Mother's Name *(First, Middle, Maiden Surname)*: Louise V, Roles

19a. Informant's Name/Relationship *(Type, Print)*: Lucretia Robinson-wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 527 Dillon Dr. Lusby Maryland 20657

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Southern Memorial Gardens Date: May 29 1997

20c. Location - City or Town, State: Dunkirk Maryland

21. Signature of Funeral Service Licensee: BRausch

22. Name and Address of Facility: Rausch Funeral Home 4405 Broomes Is. Rd. Port Republic Maryland 20676

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. SEPSIS — 2 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. CARCINOMA LUNGS — 6 months

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: COPD, HTN

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D 36969

29d. Date signed *(Month, Day, Year)*: May 26 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Scaria Mathew, M.D. 11910 H.G. Trueman Rd. Lusby MD 20657

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 28 1997

32. Registrar's Signature: Julia Davidson Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12+1

Item 19a CCHD 5/29/97 fcb

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17486

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Evelyn Roberts
2. Date of Death Month: May Day: 21 Year: 1997
3. Time of Death: 12:20 AM
4a. Facility Name (If not institution, give street and number): Southern Maryland Hospital
4b. City, Town, or Location of Death: Clinton
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 260-48-5368
6. Sex: 1☐ M 2☒ F (X)
7. Age (In yrs. last birthday): 64 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan 27, 1933
9. Birthplace (State or Foreign Country): Georgia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Forestville
10d. Inside City Limits: 1☐ Yes 2☒ No (X)
10e. Street and Number: 6308 Hil-Mar Drive Apt 4
10f. Zip Code: 20747
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married (X) 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No (X) If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No (X) Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12th
College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Food Service
16b. Kind of Business/Industry: Hotel

17. Father's Name (First, Middle, Last): Crossland Bozeman
18. Mother's Name (First, Middle, Maiden Surname): Mollie Darity

19a. Informant's Name/Relationship (Type, Print): ~~Peggy~~ PENNY Allen (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 616 Park Plaza Deale, Maryland 20751

20a. Method of Disposition: 1☐ Burial 2☒ Cremation (X) 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Lee Crematory
Date: May 23, 1997
20c. Location - City or Town, State: Clinton, Maryland

21. Signature of Funeral Service Licensee: Mark D. Parker
22. Name and Address of Facility: Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Myocardial Infarct — 36 hrs
Due to (or as a consequence of):
b. Arteriosclerotic Cardiovascular Disease — Yrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Cancer Lung

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably (X) 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No (X)
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No (X)

28. Place of Death (Check only one): Hospital: 1☒ Inpatient (X) 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural (X) 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (X) 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Thomas Fieldson MD
29c. License number: D01923
29d. Date signed (Month, Day, Year): MAY 21, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Thomas Fieldson MD 2068 Crain Highway Waldorf, MD 20601

State Registrar

31. Date filed (Month, Day, Year): MAY 27 1997
32. Registrar's Signature: Julia Davidson Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17487

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ROSE SANDLER

2. Date of Death Month: 5 Day: 20 Year: 97

3. Time of Death: 4:30pm

4a. Facility Name *(If not institution, give street and number)*: 11515 Interlachen Drive

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-34-9303

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 3-15-07

9. Birthplace *(State or Foreign Country)*: Russia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 11515 Interlachen Drive

10f. Zip Code: 20906

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Owner

16b. Kind of Business/Industry: Grocery Store

17. Father's Name *(First, Middle, Last)*: MORDECHAI LURIA

18. Mother's Name *(First, Middle, Maiden Surname)*: Miriam Stitia

19a. Informant's Name/Relationship *(Type, Print)*: Marilyn Rubinstein/Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5450 Whitley Park Terrace #210 Bethesda, MD 20814

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. Lebanon Cemetery

Date: 5/22/97

20c. Location - City or Town, State: Adelphi, MD

21. Signature of Funeral Service Licensee: Peter R. Hamm

22. Name and Address of Facility: Ives-Pearson Funeral Homes 472 N. Washington St. Falls Church, VA. 22046

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. HEART FAILURE — 12 MOS.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: NONE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Date of Injury *(Month, Day, Year)*

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

26e. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: James Karesh MD

29c. License number: D25949

29d. Date signed *(Month, Day, Year)*: 5-20-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): JAMES KARESH, MD SINAI HOSP. 2411 W. BELVEDERE, BALTIMORE MD 21215

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 23 1997

32. Registrar's Signature: Gina Davidson-Randall

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17488

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: SOL SCHWARTZ
2. Date of Death Month / Day / Year: MAY 19 1997
3. Time of Death: 10:25 PM
4a. Facility Name *(If not institution, give street and number)*: 9749 DUFFER WAY
4b. City, Town, or Location of Death: GAITHERSBURG
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 107-20-7563
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 69 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: AUGUST 5, 1927
9. Birthplace *(State or Foreign Country)*: NY

Usual Residence of Decedent

10a. State: MD
10b. County: MONTGOMERY
10c. City, Town or Location: GAITHERSBURG
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 9749 DUFFER WAY
10f. Zip Code: 20879
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: ELECTRICAL ENGINEER
16b. Kind of Business/Industry: RESEARCH

17. Father's Name *(First, Middle, Last)*: ISIDORE SCHWARTZ
18. Mother's Name *(First, Middle, Maiden Surname)*: GUSSIE SACHS

19a. Informant's Name/Relationship *(Type, Print)*: ERIC SCHWARTZ - SON
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 23 ARCHER SQUARE, OTTAWA, ONTARIO CANADA K1V 9Y8

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: WELLWOOD — Date: 5/22/1997
20c. Location - City or Town, State: FARMINGDALE, NY

21. Signature of Funeral Service Licensee: David A Stock
22. Name and Address of Facility: DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC 1170 ROCKVILLE PIKE ROCKVILLE MD 20852

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. STATUS ASTHMATICUS	3 HR.
Due to (or as a consequence of):	ASTHMA	30 YR.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: NONE

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [✓] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [✓] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ S. J. My. MD
29c. License number: D23630
29d. Date signed *(Month, Day, Year)*: MAY 20, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 16220 FREDERICK RD #213, GAITHERSBURG, MD 20877

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 22 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17489

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ronald Iee Schwartzbeck
2. Date of Death: Month May Day 17 Year 1997
3. Time of Death: 9:30 PM
4a. Facility Name (If not institution, give street and number): 10001 Burnett Ave.
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 218-64-6559
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 43 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): October 10, 1953
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 10001 Burnett Ave
10f. Zip Code: 20910
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white
15. Decedent's Education (Specify only highest grade completed): Elamantary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Janitor
16b. Kind of Business/Industry: Rock Creek Foundation
17. Father's Name (First, Middle, Last): Roland W. Schwartzbeck
18. Mother's Name (First, Middle, Maiden Surname): Louise M. Manherz
19a. Informant's Name/Relationship (Type, Print): Roland W. Schwartzbeck/Father
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9012 Eldridge Rd. Spring Hill, FL. 34608
20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetary, cremetory or other piece): Metropolitian Crematory
Date: May 19, 1997
20c. Location - City or Town, State: Alexandria, VA
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Takoma Funeral Home, Inc. 254 Carroll St. NW Washington, DC 20012

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)
a. Hypertensive Heart Disease

Due to (or as a consequence of):
b. vetr arythmia — years

Sequantially list conditions, if any, leading to immediate ceuse. Enter Underlying Causa (Disease or Injury that initiated avants resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of ceuse of death? 1 [ ] Yes 2 [ ] No

25. Was cese refarred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicida 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, straat, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To tha best of my knowledga, daath occurred at tha time, data and place, and dua to tha causa(s) and mannar as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier: [signature] MD
29c. License number: D08546
29d. Date signed (Month, Day, Year): May 17, 1997

30. Nama and address of person who completed cause of daath (Item 23a) (Type, Print): John Tauber 8218 Wisconsin Ave Bethesda Md.

State Registrar

31. Date filed (Month, Day, Year): MAY 19 1997
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pegas 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17490

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Morris M. Seigal

2. Date of Death Month: May Day: 15 Year: 97

3. Time of Death: 8:30 PM

4a. Facility Name *(If not institution, give street and number)*: Suburban Hospital

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 497-03-8436

6. Sex: X 1 M 2 F

7. Age *(In yrs. last birthday)*: 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 14, 1914

9. Birthplace *(State or Foreign Country)*: Missouri

Usual Residence of Decedent

10a. State: Md.

10b. County: Montgomery

10c. City, Town or Location: Bethesda

10d. Inside City Limits: X 1 Yes 2 No

10e. Street and Number: 7911 Robison Rd.

10f. Zip Code: 20817

10g. Citizen of What Country?: US

11. Marital Status: 1 Never Married 2 Married 3 X Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Retail Owner

16b. Kind of Business/Industry: Women's Apparel

17. Father's Name *(First, Middle, Last)*: Isadore Seigal

18. Mother's Name *(First, Middle, Maiden Surname)*: Fannie Silverstein

19a. Informant's Name/Relationship *(Type, Print)*: Eileen Beecher/ Niece

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7911 Robison Rd. Bethesda, Md. 20817

20a. Method of Disposition: X 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: King David Memorial Gardens | Date: 5/18

20c. Location - City or Town, State: Falls Church, Va.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Edward Sagel Funeral Direction 1091 Rockville Pike Rockville, Md. 20852

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. End Stage Renal Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Congestive Heart Failure

Due to (or as a consequence of):

c. Coronary Artery Disease

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 X No

25. Was case referred to medical examiner? 1 Yes 2 X No

26. Place of Death *(Check only one)*: Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA | Other: 4 Nursing Home 5 Residence 6 Other *(Specify)*

27. Manner of Death: X 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury *(Month, Day Year)* | 28b. Time of Injury M | 28c. Injury at Work? 1 Yes 2 No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: X 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D36797

29d. Date signed *(Month, Day, Year)*: 5/16/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): A. Sheff, MD 10215 Fernwood Rd, Bethesda MD

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 23 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

JW

4

Phyllis Wood Shear

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17491

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Phyllis Wood Shear
2. Date of Death (Month, Day, Year): May 16, 1997
3. Time of Death: 4:00 PM
4a. Facility Name (If not institution, give street and number): 17800 Buehler Road, #132
4b. City, Town, or Location of Death: Olney
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 108-18-8603
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 73 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 2, 1923
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10e. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Olney
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 17800 Buehler Road, #132
10f. Zip Code: 20832
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+): 4
16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Musician
16b. Kind of Business/Industry: Music, Self-employed

17. Father's Name (First, Middle, Last): William M. Wood
18. Mother's Name (First, Middle, Maiden Surname): Lucy Hovenden

19a. Informant's Name/Relationship (Type, Print): Jennifer J. Shear
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3228 Spartan Road, Olney, MD 20832

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory
Date: 5-17-97
20c. Location - City or Town, State: Beltsville, Maryland

21. Signature of Funeral Service Licensee: Ellen H. Rapp
22. Name and Address of Facility: Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. COLON CANCER — 1994 - 1997
Due to (or as a consequence of):
b. CARCINOMATOSIS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Isabella Martire
29c. License number: D45014
29d. Date signed (Month, Day, Year): May 16/1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Isabella Martire, M. D. Olmswood Court #111 Olney MD 20850

State Registrar

31. Date filed (Month, Day, Year): MAY 19 1997
32. Registrar's Signature:

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17492

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): SAM SILVERMAN

2. Dete of Deeth — Month: MAY Dey: 21 Year: 97

3. Time of Death: 1331 PM

4a. Feciility Neme (If not Institution, give street end number): Suburban Hospital

4b. City, Town, or Location of Deeth: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Sociel Security Number: 051-09-1988

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. lest birthday): 80 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Yeer): November 27, 1916

9. Birthplece (Stete or Foreign Country): Romania

Usuel Residence of Decedent

10e. Stete: Maryland

10b. County: Montgomery

10c. City, Town or Location: Bethesda

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street end Number: 6309 West Halbert Road

10f. Zip Code: 20817

10g. Citizen of Whet Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12 — College (1-4or 5+):

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Medical Photographer/Supervisor

16b. Kind of Business/Industry: National Institutes of Health

17. Father's Neme (First, Middle, Last): Morris Silverman

18. Mother's Neme (First, Middle, Meiden Surneme): Rose Kuris

19e. Informent's Neme/Reletionship (Type, Print): Mildred V. Silverman/Wife

19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 6309 West Halbert Road, Bethesda, Maryland 20817

20e. Method of Disposition: 1 [ ] Buriel 2 [X] Cremetion 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Plece of Disposition (Neme of cemetery, cremetory or other plece): Montgomery Crematorium, Inc. — Date: May 22, 1997

20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funerel Service Licensee: Michael S. Hagen M00846

22. Neme end Address of Feciility: Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Pert I. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on eech line.

Approximete Interval Between Onset end Deeth

Immediete Ceuse (Finel diseese or condition resulting in death): e. MULTIPLE TRAUMA — 22 HRS

Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest

b. Due to (or es e consequence of):

c. Due to (or es e consequence of):

d.

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24e. Was en autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings eveileble prior to completion of cause of deeth? 1 [ ] Yes 2 [X] No

25. Wes case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Plece of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Death: 1 [ ] Neturel 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28e. Dete of Injury (Month, Dey, Yeer): MAY 20 97

28b. Time of Injury: 1350 PM

28c. Injury et Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: FELL FROM LADDER

28e. Plece of Injury - At home, farm, street, fectory, offica building, etc. (Specify): HOME

28f. Location (Street end Number or Rurel Route Number, City or Town, State): #10

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred et the time, dete end place, and due to the ceuse(s) end manner es stated. 2 [X] Medical Exeminer: On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: [signature]

29c. License number: D070099

29d. Dete signed (Month, Dey, Yeer): MAY 21 97

30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print): FRANCIS C. MAYLE 1015 FERNWOOD RD BETHESDA MD 20817

State Registrar

31. Dete filed (Month, Day, Year): MAY 23 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17493

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Martha Silverstein
2. Date of Death: Month May Day 16 Year 1997
3. Time of Death: 4:00 pm
4a. Facility Name (If not institution, give street and number): Howard County General Hospital
4b. City, Town, or Location of Death: Columbia
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 213-58-7774
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 15, 1906
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Md.
10b. County: Howard
10c. City, Town or Location: Columbia
10d. Inside City Limits: X 1☐ Yes 2☐ No
10e. Street and Number: 4962 Reedy Brooke Lane
10f. Zip Code: 21044
10g. Citizen of What Country?: US

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Jacob Cohen
18. Mother's Name (First, Middle, Maiden Surname): Sarah Unknown

19a. Informant's Name/Relationship (Type, Print): Sheila Schrier /Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10775 Deborah Dr. Potomac, Md. 20854

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion Cemetery | Date: 5/18/97
20c. Location - City or Town, State: Maspeth, Ny.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Edward Sagel Funeral Direction 1091 RockvillePike Rockville, Md. 20852

JW

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Pulmonary edema	1 week
Due to (or as a consequence of): b.	Severe cardiomyopathy	years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Sepsis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Dan Ullmann MD
29c. License number: D21461
29d. Date signed (Month, Day, Year): May 16 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Barry Moar MD 2 Knoll North Drive Columbia Md

State Registrar

31. Date filed (Month, Day, Year): MAY 23 1997
32. Registrar's Signature: Julia Davidson-Randall

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17494

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Yola Mary Simms

2. Date of Death Month: May Day: 21 Year: 1997

3. Time of Death: 2010

4a. Facility Name *(If not institution, give street and number)*: Deaton Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 220-34-4284

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 58 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 10, 1939

9. Birthplace *(State or Foreign Country)*: Trinidad

Usual Residance of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Potomac

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1916 Sunrise Drive

10f. Zip Coda: 20854

10g. Citizan of What Country?: USA

11. Marital Stetus: 1☐ Never Married 2☐ Married 3☒ Widowad 4☐ Divorced

12. Was Decadent Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Give Year or Datas:

13. Was Decadant of Hispanic Orlgin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 1☐ Yas 2☒ No *Specify:*

14. Race - American Indian, Bleck, Whita, atc. *Specify:* White

15. Dacedant's Education *(Specify only highast grade complatad)*: Elemantary/Sacondary (0-12): 12 / Collaga (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Businass/Industry: Own Home

17. Fathar's Nama *(First, Middla, Last)*: Joseph K. Copeland

18. Mothar's Name *(First, Middla, Maiden Surnama)*: Agnes C. Carvalho

19a. Informent's Name/Relationship *(Type, Print)*: Kathleen Hargett

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 1916 Sunrise Drive, Potomac, MD 20854

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Nama of cematary, cramatory or othar place)*: Gate of Heaven Cemetery

Date: 5/24/97

20c. Location - City or Town, State: Silver Spring, MD

21. Signatura of Funeral Service Licensee: Ruth L. Francis

22. Nama and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that ceused tha daath. Do not antar the mode of dying, such as cardiac or raspiretory errast, shock, or heart failure. List only ona causa on aach lina.

		Approximata Interval Batwaan Onset and Death
Immedieta Causa (Finel disaasa or condition rasulting in death) a.	Acute Myocardial infarction suspected	10 minutes
Dua to (or as a consaquanca of): b.	Athorsclerotic heart disease	1 year
Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disaasa or Injury thet initiated avants rasulting in death) Last — Dua to (or as a consequence of): c.	Congestive heart failure	1 year
Dua to (or as a consequance of): d.	Anoxic encopholopathy	4 months

Part II. **Other significant conditions** contributing to daath but not rasulting in tha undarlying causa givan in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to complation of cause of death? 1☐ Yas 2☐ No

25. Was cesa refarred to medical examinar? 1☐ Yes 2☑ No

26. Place of Death *(Check only ona)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Othar: 4☐ Nursing Home 5☐ Rasidance 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding investigation 6☐ Could not be determined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28e. Place of Injury - At homa, farm, straat, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifiar *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at tha tima, data and plece, and dua to tha causa(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and mannar stated.

29b. Signatura and titla of certifier

29c. License number: D30494

29d. Data signed *(Month, Day, Year)*: 5/22/97

30. Nema and address of person who completed ceuse of death (Item 23a) (Type, Print): Deaton medical center. 100 South Charles St Baltimore MD

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

12

State Registrar

31. Data filed *(Month, Day, Yaar)*: MAY 23 1997

32. Registrar's Signatura: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 17495

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: IDA LOUISE SMITH

2. Date of Death Month / Day / Year: MAY 16, 1997

3. Time of Death: 6:32 am

4a. Facility Name *(If not institution, give street and number)*: 813 Rittenhouse Street

4b. City, Town, or Location of Death: Hyattsville

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 578-30-0624

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Apr 26, 1908

9. Birthplace *(State or Foreign Country)*: SC

Usual Residence of Decedent

10a. State: MD

10b. County: Prince Georges

10c. City, Town or Location: Hyattsville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 813 Rittenhouse Street

10f. Zip Code: 20783

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Seamstress

16b. Kind of Business/Industry: Self-employed

17. Father's Name *(First, Middle, Last)*: Tommie Diggs

18. Mother's Name *(First, Middle, Maiden Surname)*: Easter Oliphant

19a. Informant's Name/Relationship *(Type, Print)*: Julius L. Smith (Son)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 813 Rittenhouse Street, Hyattsville, MD 20783

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory

Date: 5/20/97

20c. Location - City or Town, State: Alexandria, VA

21. Signature of Funeral Service Licensee: ▶ R. N. Horton

22. Name and Address of Facility: R. N. Horton Co. Morticians, Inc. 600 Kennedy Street, N. W., DC 20011

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Hepato cellular Carcinoma — 3-4 Months

Due to (or as a consequence of):

b. Ischemic Cardiomyopathy — 6 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

Hypertension

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Arvind M. Mehta MD

29c. License number: D 27366

29d. Date signed *(Month, Day, Year)*: May 20, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Arvind M. Mehta 7100 Baltimore Avenue, Suite 509, College Park, MD 20740

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 21 1997

32. Registrar's Signature: Gina Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17496

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Lewis F. Speakman

2. Data of Deeth Month Day Year: May 16, 1997

3. Tima of Death: 11:00 PM

4a. Facility Name *(If not institution, giva street and number)*: Montgomery General Hospital

4b. City, Town, or Location of Death: Olney

4c. County of Deeth: Montgomery

Funeral Director

5. Social Security Number: 162-10-0895

6. Sax: 1☒ M 2☐ F

7. Aga *(In yrs. last birthdey)*: 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 27, 1912

9. Birthplaca *(State or Foraign Country)*: Pennsylvania

Usual Residance of Dacedant

10a. Stata: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Insida City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 15316 Pine Orchard Drive

10f. Zip Coda: 20906

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Naver Married 2☒ Marriad 3☐ Widowed 4☐ Divorced

12. Wes Dacedent Ever in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yes, Giva Yaer or Datas:

13. Was Dacedent of Hispanic Origin? (Spacify Yes or No- If Yes, specify Cuban, Maxicen, Puerto Rican, etc.) 1☐ Yas 2☒ No *Specify:*

14. Raca - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Educetion *(Spacify only highast grada complatad)*: Elementary/Secondary (0-12): 12; Collaga (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Giva kind of work done during most of working lifa. DO NOT usa retired)*: Electrical Engineer

16b. Kind of Businass/Industry: Department of Navy

17. Fathar's Nama *(First, Middla, Last)*: Wilbur Alexander Speakman

18. Mothar's Name *(First, Middla, Maidan Surnema)*: Edith Sophia dePutron

19a. Informant's Name/Relationship *(Type, Print)*: Catherine McKee Speakman

19b. Mailing Address *(Straat and Number or Rural Route Number, City or Town, Stata, Zip Coda)*: 15316 Pine Orchard Drive, Silver Spring, MD 20906

20a. Mathod of Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramoval from State 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Nama of cematary, cremetory or othar placa)*: Chesapeake Crematory

Data: 5-18-97

20c. Location - City or Town, Stata: Beltsville, Maryland

21. Signatura of Funeral Sarvice Licensaa: Carol A Dahn

22. Nama and Address of Facility: Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 20910

Physician /Medical Examiner

23a. Part I. Entar tha disaase, or complicetions thet causad the deeth. Do not anter the moda of dying, such es cardiac or raspiratory errest, shock, or haart failura. List only one causa on aach line.

Approximata Intarval Between Onset and Deeth

Immediate Ceusa (Final disaasa or condition resulting in death)

a. PNEUMONIA — Approximata Intarval: DAYS

Dua to (or es a consaquance of):

Sequantially list conditions, if any, leeding to immedieta ceusa. Enter Undarlying Causa (Disease or Injury thet initiated events resulting in death) Last

b.

Dua to (or as a consaquance of):

c.

Dua to (or as a consaquance of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying ceusa givan in Part I.

STROKE DIABETES

23b. **Did tobacco use contribute to the cause of death?** 1☐ **Yes** 2☑ **No** 3☐ **Probably** 4☐ **Unknown**

24a. Was an autopsy performed? 1☐ Yas 2☑ No

24b. Wara autopsy findings available prior to compiation of cause of death? 1☐ Yas 2☑ No

25. Was cesa rafarred to medical examiner? 1☐ Yas 2☑ No

26. Placa of Death *(Check only ona)*: Hospital: 1☑ Inpatiant 2☐ ER/Outpatiant 3☐ DOA; Othar: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending Investigation 6☐ Could not be determinad

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At homa, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifiar *(Check only ona)*: 1☑ **Certifying Physician:** To tha best of my knowledga, daath occurred at tha time, dete end place, and dua to tha causa(s) and mannar as steted. 2☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurred at the time, deta and piace, and due to the causa(s) and mennar statad.

29b. Signature and title of Cartifiar: MD

29c. License number: D38457

29d. Date signed *(Month, Day, Year)*: MAY 17, 1997

30. Nama and eddress of person who completad cause of deeth (Item 23a) *(Type, Print)*: N. GOYAL MD, 16111 PRINCE PHILIP DR, OLNEY MD 20832

State Registrar

31. Dete filad *(Month, Day, Year)*: MAY 19 1997

32. Registrer's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17497

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Emily Munson Stemple
2. Date of Death Month / Day / Year: May 18 1997
3. Time of Death: 9:15 am
4a. Facility Name *(If not institution, give street end number)*: Nanson Group Home
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 226-42-4219
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 79 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Oct. 3, 1917
9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedant

10e. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3526 Twin Branches Drive
10f. Zip Code: 20906
10g. Citizen of What Country?: USA

11. Maritel Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Bleck, White, etc. *Specify:* White

15. Decedent's Educetion *(Specify only highest grede completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 1
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Secretary
16b. Kind of Business/Industry: Education

17. Father's Name *(First, Middle, Last)*: Richard Horton
18. Mother's Name *(First, Middle, Meidan Surnama)*: Ella Munson

19a. Informent's Name/Relationship *(Type, Print)*: James E. Stemple
19b. Mailing Addrass *(Street and Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 3526 Twin Branches Drive, Silver Spring, MD 20906

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Ramovel from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or othar piece)*: Columbia Gardens Cemetery
Date: 5/22/97
20c. Location - City or Town, State: Arlington, VA

21. Signature of Funeral Service Licensee: Robert K Ramsey
22. Name and Address of Facility: Francis J. Collins Funeral Home Inc. 500 University Blvd. West Sil.Spring, MD 20901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or haart failure. List only one cause on each line.

Approximate Interval Batwean Onset end Death

Immediate Cause (Final disease or condition resulting in daath)
a. Cardiac Arrhythmia, Arrest — Sudden

Due to (or as a consequenca of):
b. Cardiac Arrhythmia, Heart Block, Pacemaker — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or Injury thet initiated events resulting in death) Last

Due to (or as a consequence of):
c. Cardiomyopathy — years

Due to (or as a consequence of):
d. Sjogrens Syndrome + Systemic Lupus — years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.
Dementia, Bronchitis, Interstitial lung fibrosis, Hypergammaglobulinemia Hyperviscosity, Ivermectin

23b. Did tobacco use contribute to tha cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings evellable prior to completion of ceuse of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Deeth *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* Asst. Living.

27. Manner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, atc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Phyalcian:** To tha best of my knowledga, daath occurred at the tima, date and place, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of axamination and/or investigation, in my opinion, daath occurred at tha tima, date and place, and due to the causa(s) and manner statad.
29b. Signature and titla of certifier: Owen J Lawless MD
29c. License number: D25400
29d. Date signed *(Month, Dey, Yaer)*: May 19th 1997

30. Name and addrass of parson who complated causa of death (Item 23a) (Type, Print): DR. O.J. LAWLESS, 3801 International Drive, Silver Spring, MD 20906

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 20 1997
32. Registrar's Signature: Jonathan Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haalth end Mental Hygiene.
Important: If item 27 is marked other then "naturel', or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that tha death certificate be executed within 24 hours after death.
To the Funeral Director: Aftar this certificate has been signed by the attending physician and completely filled in by the funeral director, paga 2 should be datached for use as the burial-transit

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17498

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Thespina Stephanos

2. Date of Death Month: May Day: 19 Year: 1997

3. Time of Death: 12:20 AM

4a. Facility Name *(If not institution, give street and number)*: Atlantic General Hospital

4b. City, Town, or Location of Death: Berlin

4c. County of Death: Worcester

Funeral Director

5. Social Security Number: 579-62-7622

8. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 94 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Aug. 27, 1902

9. Birthplace *(State or Foreign Country)*: Turkey

Usual Residence of Decedent

10a. State: Maryland

10b. County: Worcester

10c. City, Town or Location: Berlin

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1565 C Ocean Pines

10f. Zip Code: 21811

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): N/A; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife

18b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Constantine Karapantelakis

18. Mother's Name *(First, Middle, Maiden Surname)*: Archundoula Karapantelakis

19a. Informant's Name/Relationship *(Type, Print)*: Dooley Stephanos / Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1565 C Ocean Pines, Berlin, Maryland 21811

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Arlington National Cem.

Date: 5/23/97

20c. Location - City or Town, State: Arlington, Virginia

21. Signature of Funeral Service Licensee: Charles W Hastings

22. Name and Address of Facility: HASTINGS FUNERAL HOME, SELBYVILLE, DELAWARE 19975

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure — 1-2m

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 8☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: WR Schmits

29c. License number: D17596

29d. Date signed *(Month, Day, Year)*: 5/19/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W. Richard Schmits, M.D. 9733 Healthway Dr., Berlin, MD 21811

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 23 1997

32. Registrar's Signature: Donna Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17499

Physician /Medical Examiner

1. Decedent's Nema *(First, Middle, Last)*: Willie Seward, Jr.
2. Data of Daath — Month: 5 Day: 17 Yaar: 97
3. Tima of Deeth: 0930
4a. Facility Name *(If not institution, giva straat and number)*: PENINSULA REGIONAL MEDICAL CENTER
4b. City, Town, or Location of Daeth: SALISBURY
4c. County of Deeth: WICOMICO

Funeral Director

5. Social Security Number: 264-56-9300
6. Sex: 1☒ M 2☐ F
7. Aga *(In yrs. last birthday)*: 55 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sept 8, 1941
9. Birthplace *(State or Foreign Country)*: FL

Usual Residance of Dacedent

10a. Stata: VA
10b. County: Accomac
10c. City, Town or Location: Atlantic
10d. Inside City Limits: 1☐ Yas 2☒ No
10e. Street end Numbar: P. O. Box 99
10f. Zip Coda: 23303
10g. Citizan of What Country?: U.S.

11. Marital Status: 1☒ Never Marriad 2☐ Marriad 3☐ Widowad 4☐ Divorcad
12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No — If Yas, Giva Year or Datas:
13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.): 1☐ Yas 2☒ No *Specify:*
14. Raca - Amarican Indian, Black, Whita, atc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade complatad)*: Elamentary/Sacondary (0-12): 8th — Collaga (1-4or 5+):
16a. Dacedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratirad)*: Laborer
16b. Kind of Businass/Industry: Various

17. Father's Nama *(First, Middla, Last)*: Abraham Seward
18. Mothar's Name *(First, Middla, Maiden Sumama)*: Daisey Mae Futch

19a. Informant's Name/Ralationship *(Type, Print)*: Daisey Mae Ware/mother
19b. Mailing Address *(Straat and Number or Rural Route Number, City or Town, Stata, Zip Coda)*: 116 Anderson Ave., Sanford, FL 32771

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Othar *(Specify)*
20b. Placa of Disposition *(Nama of cematery, cramatory or other placa)*: Evergreen Cemetery — Data: 5/24/97
20c. Location - Clty or Town, Stata: Sanford, FL

21. Signeture of Funaral Service Licansee: [signature]
22. Nama and Address of Facility: Lewis N. Watson Funeral Home, 1618 West Rd., Salisbury, MD 21801

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complicetions that caused the daath. Do not enter the moda of dying, such as cardiac or respiratory errast, shock, or heart failura. List only ona causa on each lina.

Approximate Interval Between Onset and Death

Immadiata Causa (Final diseese or condition resulting in daeth): a. Metastatic Esophageal Cancer — 2yrs

Dua to (or as a consequanca of):

Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that initiated avants resulting in daath) Last:
b.
Due to (or as a consaquanca of):
c.
Dua to (or as a consaquanca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha undarlying causa givan in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Ware autopsy findings eveilable prior to complation of causa of daath? 1☐ Yes 2☒ No

25. Was casa rafarrad to medical examinar? 1☐ Yes 2☒ No

28. Placa of Death *(Check only one)*: Hospital: 1☒ Inpatiant 2☐ ER/Outpatient 3☐ DOA — Othar: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be determinad

28a. Data of Injury *(Month, Day, Year)*
28b. Tima of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Placa of Injury - At homa, farm, straat, factory, offica building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifiar *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowladga, death occurred at tha tima, data and placa, and due to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the causa(s) and manner stated.

29b. Signature and title of certifiar: [signature] MD
29c. License number: D26278
29d. Date signed *(Month, Day, Year)*: 5-17-97

30. Nama and address of person who completed causa of death (Item 23a) (Type, Print): David Cowall MD 145 E. Carroll St. Salisbury MD 21801

State Registrar

31. Data filed *(Month, Day, Year)*: MAY 20 1997
32. Registrar's Signatura: [signature]

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 17500

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Frederick P. Schumann

2. Dete of Deeth — Month: May; Dey: 18; Yeer: 1997

3. Time of Deeth: 6:00 PM

4e. Feciility Name *(If not institution, give street end number)*: Salisbury Center: Genesis ElderCare

4b. City, Town, or Locetion of Deeth: Salisbury, MD

4c. County of Deeth: Wicomico

Funeral Director

5. Social Security Number: 198-01-2524

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 86 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Yeer)*: Jun 5, 1910

9. Birthplace *(Stete or Foreign Country)*: Pennsylvania

Usuel Residence of Decedent

10a. Stete: Md.

10b. County: Wicomico

10c. City, Town or Locetion: Salisbury

10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street end Number: 108 Carolyn Ave.

10f. Zip Code: 21804

10g. Citizen of Whet Country?: U.S.A.

11. Meritel Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Rece - Americen Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8; College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Farmer

16b. Kind of Business/Industry: Own Farm

17. Fether's Neme *(First, Middle, Last)*: John Frederick Schumann

18. Mother's Name *(First, Middle, Meiden Surname)*: Caroline Baumann

19e. Informent's Name/Reletionship *(Type, Print)*: Dorothy J. Schumann (Wife)

19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 108 Carolyn Ave., Salisbury, Md. 21804

20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Wicomico Memorial Park

Dete: 5/21/97

20c. Location - City or Town, State: Salisbury, Md.

21. Signeture of Funeral Service Licensee: Duald C Bounds

22. Neme and Address of Feciility: Bounds Funeral Home, Salisbury, Md. 21804

Physician /Medical Examiner

23e. Pert 1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Deeth

Immediate Cause (Finel diseese or condition resulting in deeth)

e. My medical injury — min.

Due to (or as a consequence of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in deeth) Lest

b. Renal insufficiency — yrs.

Due to (or es e consequence of):

c. Anemia — yrs.

Due to (or es e consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Pert I.

23b. Did tobacco use contribute to the cause of deeth? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings eveilable prior to compiation of ceuse of deeth? 1☐ Yes 2☐ No

25. Wes case refarred to medical examiner? 1☐ Yes 2☑ No

26. Piece of Deeth *(Check only one)*: Hospital: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☑ Nursing Home 5☐ Residence 6☐ Othar *(Specify)*

27. Manner of Death: 1☑ Neturel 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28e. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Locetion *(Street end Number or Rurel Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, deta end place, end due to the ceuse(s) and mennar as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signeture end titie of certifier: [signature]

29c. License number: 029749

29d. Dete signed *(Month, Dey, Yeer)*: 5/20/97

30. Neme end address of person who completed causa of deeth (Item 23e) (Type, Print): William Robins, M.D. 1104 Healthway Dr., Salisbury, MD 21804

State Registrar

31. Deta filed *(Month, Dey, Yeer)*: MAY 20 1997

32. Registrar's Signeture: John Lawrence Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

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